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ABSTRACT

This document contains the second in a series of Congressional hearings being held by the Select Committee on Children, Youth, and Families to examine substance abuse among pregnant and parenting women and to explore prevention and treatment strategies. In his opening statement, Committee Chairman George Miller expresses hope that testimony provided at this hearing in Detroit (Michigan) will describe an exceptional model for the treatment of young women who are addicted and pregnant and will offer new information about these women that will facilitate treatment. Brief statements are included from Representatives Holloway and Bliley. Witnesses providing testimony include: (1) William Atkins, director, and William Hall, associate director, Illinois Department of Alcoholism and Substance Abuse; (2) Charlene Johnson, president, Reach, Inc. and Lee Earl, pastor and chairman of the board, Reach, Inc.; (3) Maisha Kenyatta, director, Hope, Unity and Growth, Inc.; (4) Marilyn Poland, associate professor, department of obstetrics and gynecology, Wayne State University Medical School, Detroit, Michigan; (5) Lisa Potti, program coordinator, Mother and Infant Substance Addiction Network, Detroit Health Department; (6) Beth Glover Reed, associate professor of social work and women's studies, University of Michigan; (7) Joyce Scott, executive director, West Side Futures, Chicago, Illinois; (8) Randall Todd, director, Health Promotion and Disease Prevention, Kent County Health Department, Grand Rapids, Michigan; (9) Joan Walker, administrator, office of substance abuse services, Michigan Department of Public Health; and (10) Courtney X, parent, accompanied by Beverly Chisholm, director, Eleonore Hutzel Recovery Center, Detroit, Michigan. Relevant supplemental materials, prepared statements, and letters are included throughout the text. (NB)

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GETTING STRAIGHT: OVERCOMING TREATMENT BARRIERS FOR ADDICTED WOMEN AND THEIR CHILDREN

ED325787

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

HEARING HELD IN DETROIT, MI, APRIL 23, 1990

Printed for the use of the
Select Committee on Children, Youth, and Families

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GETTING STRAIGHT: OVERCOMING TREATMENT BARRIERS FOR ADDICTED WOMEN AND THEIR CHILDREN

MONDAY, APRIL 23, 1990

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The select committee met, pursuant to call, at 9:44 a.m., in the Auditorium, Hutzel Hospital, 4704 St. Antoine, Detroit, Michigan, Hon. George Miller (chairman of the committee) presiding.

Members present: Representatives Miller, Levin, Durbin, and Holloway.

Staff present: Jill Kagan, deputy staff director; May Kennedy, professional staff; Carol Statuto, minority deputy staff director; Cathy Deeds, research assistant.

Chairman MILLER. The committee will come to order. We will try to get started here if my colleagues will come join us.

My name is George Miller and I am the Chairman of the Select Committee on Children, Youth, and Families.

This is the second in a series of hearings that the select committee is conducting. The title of today's hearing is "Getting Straight: Overcoming Treatment Barriers for Addicted Women and Their Children." Last week in Washington, D.C., in our first hearing, we tried to focus on some of the women who are addicted, some of the environments they came from, some of the problems that they have. We are recognizing that if we are going to deal with the issue of the some 375,000 or more babies each year that are born addicted to drugs and alcohol and nicotine, we are in fact going to have to start dealing with the mothers of those children and deal with the education and prevention models that will help us to reduce the numbers of children that we see born addicted each year.

And I want to thank very much Hutzel Hospital for all of their help in putting this hearing together, and Congressman Levin's office and Senator Levin's office, for their help and their support to the select committee in bringing this hearing to Detroit. We think we are going to hear not only about an exceptional model for the treatment of young women who are addicted and pregnant, but also some new information about these women that may help us provide more insight for our colleagues on how we can treat—best treat these women.

It was said by every member of the committee that was present at the hearings last week that none of us believes that the answer is to throw these women in jail. I think it is also very clear that we

are going to have to present to the public a rational and a viable treatment model for women who want treatment and who seek it out, that we can provide a means so that we can prevent some of the life-threatening problems that now occur to themselves and to their babies.

This series will continue as we try to pull apart some of the complexities that the addiction of these women and the birth of these babies present to us as a society.

[Opening statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

During the last few years, the Select Committee on Children, Youth, and Families has tracked the dramatic increase in substance abuse and its devastating effects on families and communities. In 1989, as many as 1 in 10 pregnant women used crack-cocaine, and millions more used other legal and illicit drugs, including alcohol and tobacco, that pose serious and potentially life-threatening problems to themselves and their babies.

We have become most aware of the tragic impact of perinatal substance abuse on children. In this series of Select Committee hearings, we are directing more attention to addicted women themselves, to better understand the paths to recovery and self-sufficiency for them and their children.

At the Select Committee's first inquiry into the effects of parental substance abuse on infants in 1986, we heard about the need to provide adequate services to women before, during and after pregnancy to ensure healthier birth outcomes and reduce the incidence of perinatal substance abuse. Witnesses also confirmed what we already know: it is more humane and cost-effective to provide adequate early care and treatment than to solve neglected and entrenched problems.

Despite the growing needs and rising public concern since then, we have learned that adequate treatment and support still are unavailable. A Select Committee survey of hospitals in large metropolitan areas last year revealed that two-thirds had no place to refer substance-abusing pregnant women for treatment.

Of the handful of drug treatment programs that accept pregnant women, most ignore critical service needs such as child care and transportation.

And, with nowhere to turn for treatment, women in more than a dozen states are also facing jail sentences for fetal drug exposure.

In our first hearing of the series last Thursday, the Committee learned about the nature of addiction among women and their special needs that must be addressed to enhance recovery.

We learned that the substance-abusing woman is not easily categorized. She may be economically well-off or poor, white or of color, crack-user or alcoholic, young or old. She began abusing drugs because of a complex combination of physical, environmental and social factors. Many of these women have a history of substance abuse in the family, were physically and/or sexually abused, lack self-esteem, or live in a community where substance abuse is prevalent and overpowering.

We heard from a former substance abuser, Kathy, who shared with us her own painful experience with substance abuse. She made it very clear that a substance-abusing mother is not an evil, uncaring person. Rather, she is a confused person—one who loves her children, but who, without adequate treatment, can have almost no chance of overcoming her addiction and becoming the mother to her children she wishes she were.

Just as the nature of addiction is complex, we learned that the path to recovery is equally complicated. We simply do not know what constitutes successful completion of treatment. Does any relapse mean failure? Does a brief relapse after 6 months of sobriety mean failure? Are there multiple measures of success?

In this hearing today, we will explore further women's treatment needs, the best routes to recovery, and the barriers that must be overcome.

This morning we had the privilege of touring a model treatment program, the Eleonore Hutzel Recovery Center, and met with women who receive treatment there to hear about their lives and concerns, their struggles and their successes.

We learned that this program offers a wide range of inpatient and residential services to women who are pregnant or of childbearing age, and to their families. Lack of child care, a major barrier to treatment for many women, is overcome at Hutzel by allowing children under five to live at the residential facility with their

mothers, and through a day program of counseling, learning and recreation for children.

Unfortunately, the impressive work of Hutzel Hospital can benefit only a small segment of a large and growing population of substance abusing women of childbearing age. Waiting lists are long and growing.

Hutzel delivers 9,000 babies a year, and almost half of these babies were drug-exposed before birth. Statewide estimates suggest that at least 13,000 children are born exposed to illegal drugs alone each year.

Today we will hear about other efforts in the state and in the region that are struggling to keep up with the skyrocketing demand for supportive services and treatment for women with substance abuse problems. We will also hear about a successful effort to curtail smoking among the highest-risk pregnant women at a WIC clinic in Kent County.

New data will also be released that tell us more about who these women are and about the substandard care they often receive, and provide further evidence that pregnancy may be the best time for intervention.

The Committee welcomes and thanks the researchers, treatment providers and public agency representatives who have taken the time to appear before us to expand our understanding of critical treatment issues. We are especially pleased to welcome Courtney "X" who has received services here at Hutzel and will share her personal experiences.

I would like to express our great appreciation to Hutzel Hospital and the Recovery Center for their assistance in preparing for and hosting this important hearing.

Again, thank you all for coming. I look forward to your testimony.

WOMEN, ADDICTION, AND PERINATAL SUBSTANCE ABUSE

FACT SHEET

ILLICIT DRUG USE UP AMONG MILLIONS OF WOMEN ACROSS SOCIOECONOMIC GROUPS

- Over 5 million women of childbearing age (15-44) currently use an illicit drug, including almost 1 million who use cocaine and 3.8 million who use marijuana. (National Institute of Drug Abuse [NIDA], 1989)

- In a recent survey of 715 pregnant women in Pinellas County, Florida, nearly 15% tested positive for substance use, with no significant difference among socioeconomic groups. (National Association for Perinatal Addiction Research and Education [NAPARE], 1989)

- While actual drug use may not be significantly higher among pregnant minority women, they are ten times more likely than white women who use drugs to be reported to child abuse authorities. (NAPARE, 1989)

HEAVY SMOKING, ALCOHOL USE ON THE RISE AMONG YOUNG WOMEN

- Approximately 6 million American women are alcoholic or alcohol abusers. Despite stable drinking patterns among the general population over the past 25 years, recent studies indicate an increase among younger women who are heavy drinkers (5 drinks a day or more). (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1987; NIAAA, unpublished, 1990)

- Nearly 24% of American women smoke and the fastest growing group of smokers in this country are women under age 23. Every day, 2,000 young women start smoking. The percentage of women who smoke 25 or more cigarettes a day increased from 13% in 1965 to 23% in 1985. (Surgeon

General's Report [SGR], 1989; U.S. Department of Health and Human Services [DHHS], February 1990)

- Although pregnant women are just as likely as nonpregnant women to have ever smoked (43% to 45% respectively), pregnant women (21%) are less likely than nonpregnant women (30%) to be current smokers. Black women were the least likely of any group to smoke during pregnancy. (Williamson, 1989)

PREGNANT SUBSTANCE ABUSERS AT GREAT RISK OF AIDS, SEXUALLY TRANSMITTED DISEASES AND HOMELESSNESS

- In a survey of 337 pregnant substance abusers in 63 AIDS demonstration projects nationwide, 20% are homeless and 23% spent time in jail six months prior to the interview. (NIDA, unpublished data, 1990)

- Of the same 337 women, 36% engaged in sex for drugs or money, placing themselves and their babies at high risk for HIV infection; 98% engaged in vaginal sex, while only 4% used condoms consistently; and 15% had a sexually transmitted disease in the past 6 months. (NIDA, 1990)

- In New York City, pregnant cocaine abusers were 4.5 times more likely than nonusers to have a sexually transmitted disease. (New York City Department of Health [NYCDH], September 1989)

TREATMENT/PRENATAL CARE ELUSIVE FOR SUBSTANCE-ABUSING PREGNANT WOMEN AND MOTHERS

- At Boston City Hospital, 80% of mothers surveyed who used heroin or cocaine received no prenatal care. New York City cocaine abusers were 7 times less likely than non-abusers to have received prenatal care. (Amaro, 1989; NYCDH, 1989)

- Of 78 drug treatment programs surveyed in New York City, 54% exclude all pregnant women; 67% will not accept

pregnant women on Medicaid; and 87% will not accept pregnant crack-addicted women on Medicaid. (Chavkin, 1989)

- Of California's 366 publicly-funded drug treatment programs, only 67 treat women and only 16 can accommodate her children. Similarly, Ohio has 16 women's recovery programs, and only two can accommodate her children. (Weissman, 1990; Ohio Department of Health, 1990)

- Reports show that 23% of women entering treatment, as compared to only 2% of men, encounter opposition from families and friends. Similarly, 48% of women experienced problems due to entering treatment, as compared to 20% of men. (Beckman and Amaro, 1984)

EFFECTIVE TREATMENT APPROACHES DOCUMENTED

- Pregnant women who participated in a smoking cessation program at a Michigan WIC clinic were 3.6 times more likely to quit smoking than nonparticipants. (Mayer, 1990)

- In a study of alcohol-using pregnant women in Atlanta, 35% discontinued alcohol use when presented information on the potential harm of alcohol use during pregnancy. (Smith, 1986)

- In Pinellas County, Florida, 77% of male and female substance abusers who are referred by the courts to Operation PAR, a comprehensive drug treatment program, and who complete the 18-to 24-month program do not re-enter the criminal justice system. (Florida Department of Corrections, 1989)

- Of 54 babies born in 1989 to cocaine-using mothers enrolled at the Philadelphia Family Center, an outpatient drug treatment program for pregnant women and children, 75% were carried to full term. None were born prior to 33 weeks gestation. (Philadelphia Family Center, 1990)

INFANTS SERIOUSLY AFFECTED BY PERINATAL SUBSTANCE ABUSE

- A new eight-city survey reported that nearly 9,000 babies were born exposed to illicit drugs in 1989 at an estimated cost of $500 million for providing care through age five. (Office of the Inspector General, 1990)

- Each year, Fetal Alcohol Syndrome (FAS) affects nearly 5000 babies and is the third leading cause of birth defects associated with mental retardation. Thousands more children are born with Fetal Alcohol Effects (FAE), a milder form of FAS. (National Council on Alcoholism and Drug Dependency, 1988)

- Smoking increases premature deliveries, spontaneous abortions and still births. A pregnant smoker's infant is on average seven ounces lighter than babies of nonsmokers. (SGR, 1989)

- Between 1985 and 1988, the number of congenital syphilis cases increased by 130%. Experts estimate that there will be over 1000 congenital syphilis cases in 1989. (Centers for Disease Control [CDC], 1990)

- As of February, 1990, there have been 2,116 reported cases of pediatric AIDS in children under age 13. Eighty percent of these pediatric AIDS cases are attributed to maternal transmission from an infected parent, and of these, 90% of the babies' mothers either use intravenous drugs or had heterosexual partners who were IV drug abusers. (CDC, 1990)

TREND TO PROSECUTE PREGNANT SUBSTANCE ABUSERS PROCEEDS

- To date, over thirty women have been criminally charged for drug use during pregnancy for delivery of drugs to a minor. A Florida woman has been convicted. Hundreds more pregnant substance abusers have been civilly charged

for alleged child abuse. (American Civil Liberties Union [ACLU], February 1990)

- Four states have amended definitions of child abuse to include drug use during pregnancy (Florida, Illinois, Oklahoma, Rhode Island) and 3 states have included alcohol and drug use during pregnancy (Indiana, Nevada, Utah); one state amended its definition of criminal child neglect to include prenatal exposure to controlled substances (Minnesota); and three states require doctors to report to the state if either the mother or the child has a positive urine toxicology screen (Minnesota, Oklahoma, Utah). (ACLU, February 1990)

4/19/90

Chairman MILLER. And now I would like to recognize Congressman Levin for any remarks that he may have.

Mr. LEVIN. Thank you, Mr. Chairman. Just briefly, when I was born in this hospital a few years ago, as was my wife and two of our children, especially as to my wife and myself, the hospital had a somewhat different function. It was delivering babies with a variety of conditions, but under somewhat different conditions than prevail here today. The hospital is very much on the firing line as America decides how much we are going to face up to a major problem.

This hospital and all of the institutions affiliated with it are I think—and we will hear much more of this in the testimony—pioneering—sounding an alarm for this country.

And so I am pleased to join you, George, and my two colleagues from Illinois and Louisiana and we look forward very much to the testimony. I hope everybody who does present their testimony today will understand, will realize that what you say hopefully will be heard not only within these four or six walls, however many there are here, but beyond these walls.

Under George Miller's leadership, this committee has, I think, sounded an alarm for an entire nation and we are today looking at another aspect of a very, very pressing problem facing the children of America and their parents.

So welcome to this blessed hospital.

Chairman MILLER. Thank you.

Congressman Holloway?

Mr. HOLLOWAY. Just a few words to say, Chairman Miller.

Of course we are very appreciative of the opportunity to be here and educate ourselves. I think there is a great deal of knowledge that we need to learn in Washington to deal with the situation. I think many of us have a lot of false pretense, a lot of false thoughts about the problems and the solutions. Of course it is our job as Members of the House to try to fund programs, but also to give the taxpayers the most for their buck, to decide what is right and what is wrong. I do find this to be a field, from what I have read, in which there is not a lot of statistics, there is not a lot of knowledge and not a lot of follow-up figures. And I think we can surely accomplish that and hopefully much more from these hearings, and I look forward to them.

I enjoyed the tour this morning, it was very informative to us, to look at the children, look at very normal looking children, and hopefully as they grow up to be adults they will be very normal children.

Thank you.

[Opening statement of Hon. Clyde C. Holloway follows:]

OPENING STATEMENT OF HON. CLYDE C. HOLLOWAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

I want to thank the Select Committee on Children, Youth, and Families for holding this hearing on drug abuse treatment for women today. I believe this is an important topic not only for the committee but also for my colleagues here and back in Washington.

This problem of substance abusing women, especially pregnant women, is a growing concern in all cities, but especially for places such as the inner city Detroit. The specific issue we will look at today—treatment of these women—is a more complex one. Unfortunately, there have been few longitudinal studies of women or babies to

tell us the most effective type of treatment model. The presence of crack cocaine, as a highly addictive illegal substance, poses new problems for these women and their babies.

Today we will hear from experts on the special treatment needs of substance-abusing women, using the Eleonore Hutzel Recovery Center as a model. We must also keep in mind the special treatment needs of the baby, whether unborn or born. Treatment, in lieu of jailing mothers, must be strongly encouraged for pregnant mothers. In cases where the addicted mother is unresponsibe to treatment, or simply leaves her baby at the hospital to become a "boarder baby", adoption must be encouraged as a caring alternative.

I want to thank the Republican witnesses, Charlene Johnson and Maisha Kenyatta especially, for their innovative, community-based drug prevention and treatment efforts. Mrs. Johnson's and Pastor Lee Earl's REACH program was recently recognized by President Bush as a "Point of Light." REACH involves the Twelfth Street Missionary Baptist Church in Detroit assisting the local community "to develop its own indigenous institutions and skills necessary to solve its own problems."

I would hope other concerned citizens and church groups in Detroit and elsewhere will follow these courageous examples and take action to help women and families break out of deadly drug-addiction patterns.

Chairman MILLER. Thank you.

Congressman Durbin.

Mr. DURBIN. Thank you very much, Mr. Chairman, and thank you for the opportunity to be here today.

We have already started the day with a very interesting site visit and I want to thank Beverly Chisholm, Dr. Wardell and staff for showing us through their recovery center. It is an eye-opener for those who read about the statistics and read about this problem to actually see the people who are involved and to actually see the small infants whose lives are affected by this addiction.

Dr. Wardell spoke of his entry into this field some 21 years ago, worrying then over heroin addiction and how things have changed and still yet remain the same with the addictive personality and the addictive mother and the problems created for the children as a result of it.

There are many innocent victims in drug addiction and certainly everyone would agree that the most innocent victims are these children who come into the world unknowing that they carry with them a problem from the instant of birth that has to be resolved.

Lest anyone believe this is a problem of New York City, Washington, D.C., Detroit and Los Angeles, I might tell you that in my home state of Illinois even outside of the City of Chicago, we are running into substance addiction among mothers in the most rural areas. It is a national problem that needs a national approach, a national solution.

Today, you will help to open our eyes and hopefully we can take the message back to Washington to make our federal policy a consistent one that produces the kinds of results that we all hope for.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you. With that we will hear from our first panel if they will come forward. First is Courtney, who will be accompanied by Beverly Chisholm, who is the Director of the Eleonore Hutzel Recovery Center; Dr. Marilyn Poland, who is Associate Professor, Department of Obstetrics and Gynecology, Wayne State University; Joan Walker, who is the Administrator for the Office of Substance Abuse Services, Michigan Department of Public Health; William T. Atkins, the Director of the Illinois Department

of Alcoholism and Substance Abuse, who will be accompanied by William G. Hall, the Associate Director of the Illinois Department of Alcoholism and Substance Abuse; and Dr. Beth Glover Reed, who is Associate Professor of Social Work and Women's Studies, University of Michigan.

Do we have enough chairs there? We may have to rotate back and forth.

Welcome to the committee. Your written statements will be put in their record in their entirety and we will ask you to proceed in the manner in which you are most comfortable.

Courtney, a special welcome to you. One of the things that this Committee has tried to do is to hear from some of the children, youth and family members on subjects that we are taking testimony on and having hearings. We feel that it is important for members to hear directly from people involved in the programs as recipients.

Last week, we heard from a young mother who had been addicted for many years, tragically had a couple of her children die but I think explained to this committee the long process it took her and the time it took her to become sober and to stay that way now for the past six years, and much like you are doing here today, she is now working with other mothers, helping them in a program. But I think members were quite taken, hearing first-hand her struggle and her efforts. So we welcome you to the committee, as we do all of you.

I think the one thing we may change is, Marilyn, if it is all right with you, we may let Joan go first because I think there is a time problem here in terms of leaving.

So Courtney, we are going to start with you. Welcome.

STATEMENT OF COURTNEY X, PARENT, ACCOMPANIED BY BEVERLY J. CHISHOLM, DIRECTOR, ELEONORE HUTZEL RECOVERY CENTER, DETROIT, MI

Ms. X. I would like to thank the Select Committee on Children, Youth, and Families——

Chairman MILLER We are going to need you to boom your voice out here. There are a lot of interested people who are too embarrassed to come sit down front, we will have to talk to them all the way up there.

Ms. X. All right, excuse me.

I would like to thank the Select Committee on Children, Youth, and Families for allowing me this opportunity to tell my personal story.

I have a history of substance abuse that started at age 14. At the young age of 14, I was cross-addicted to marijuana and beer. At that time, I was curious about the "high" and I had a need to get the courage to entertain my peers. The marijuana made me laugh a lot and I liked that.

At 16, I started to drink liquor, added mescaline, stayed on marijuana and drank beer and threw in pills for good measure.

At 17, I added crack cocaine to my daily usage pattern. Eventually the other drugs could not compete with the ultimate high I felt I got from crack. I had this sense of conquering, a feeling that the

world was at my command. For two years the drug continued to satisfy my craving for all drugs and I had become a loyal subject to freebasing.

At the age of 19, I gave birth to my first child. With my parents' assistance, a decision was made for me to place this child up for adoption. When I saw the child, I immediately changed my mind about adoption. I contacted Catholic Social Services and stated that I had changed my mind about adoption, the child was placed in temporary foster care with a Caucasian foster parent.

The child remained in foster care for 14 months in the same home. All the time the child was in foster care, I kept thinking I would get my life together and reunite with my baby. I did make a serious effort to plan for the baby to come home. I started back using drugs and committed myself to a long term residential treatment program. When my child would come to visit me, he was older, he did not know me, he cried for the mother he knew. When these caring people asked me to let them raise my son, I knew in my heart that it was the best solution for my young son and with a heavy heart but a sense of knowing I was doing the right thing, I agreed.

At the age of 21, I gave birth to my second son. Between the births of my sons, I encountered my heaviest usage patterns. I was feeling so alone, empty and unwanted. I moved out of my mother's home and decided to go to Chicago and start a new life. What I found in Chicago was my old life in a new city; cocaine was there too. This child's father supplied me with drugs until he went to jail. My relatives were straight people, they neither understood addiction nor wanted it in their home. I was in the streets of Chicago pregnant, alone and addicted.

My father financed the trip back to Detroit, returning me to my mother. That was his idea and what I returned to was my addiction. I had this second child in my addiction, left the hospital before the baby was released, I never returned to pick the child up. Protective Services took custody of the child and he was placed up for adoption.

You have to understand that an addicted mind is not a rational, reasonable one. The thought of returning for my baby never occurred to me. I am not an uncaring person, I have a disease known as substance abuse and I have been very ill. You have to understand that.

My family tried to understand, wanted to help me, but they did not know how and eventually I felt I was successful in showing them that they could not help me. They stopped trying.

After seve al treatments and delivering my baby at Hutzel Hospital, I learned of the Eleonore Hutzel Recovery Center. This child was born out of my addiction, weighed one pound and eight ounces. The treatment program assisted me in understanding that I could rehabilitate and care for my child. While my baby struggled for survival, I continued with treatment. By the time I had my son, I was tired. I was tired of using, tired of being used, tired of being afraid of the unknown, tired of trying to be straight just to meet another crisis and slip back into the old familiar patterns, tired of being tired.

When I walked into the doors of Eleonore Hutzel Recovery Center, I came admitting my powerlessness over my addiction. I was ready to be taught what I needed to know to survive out here in the real world. I was ready to turn my will over to God and today I am so grateful—I am so grateful—that He gave me this chance to seek and find the help that I needed.

EHRC provides many services to women and their children. What the staff has taught me most is how to care, how to care about me. The staff cares for all of us but there is always the feeling of being cared for as a person.

Today, I live in Eleonore Hutzel East (domicile), with my baby that now weighs seven pounds. I am learning every day how to cope with my addiction as a disease. I am learning parenting and today I am a parent. EHRC has provided me with the necessary tools, it is my responsibility to use these tools and I plan to for the rest of my life. I have a family that I met in EHRC, they are also my support system.

On May 18, 1990, I will move forward from EHRC, the treatment will have ended. Although I am nervous about the outside world, I will be confident knowing that I have a place in EHRC that will always belong to me and I will never to be alone again. All I have to do is contact my family.

Thank you.

[Applause.]

Ms. X. Oh, excuse me, I am sorry.

Chairman MILLER. Encore.

Ms. X. I would like to close by saying people do recover. No one, including me, would have ever thought that a person with my history would some day tell her story of sobriety to a group such as this. But here I am, drug free, happy, proud of my achievements and grateful for all those who have dedicated their lives to helping those in need.

Thank you. [Applause.]

Chairman MILLER. Thank you, Courtney, very much for that.

We are going to go ahead and hear from the rest of the witnesses and then we will have questions from members of our panel.

Joan.

[Prepared statement of Courtney X follows:]

PREPARED STATEMENT OF COURTNEY X, ELEONORE HUTZEL RECOVERY CENTER, DETROIT, MI

I would like to thank the Select Committee on Children, Youth, and Families for allowing me this opportunity to tell my personal story.

I have a history of substance abuse that started at age 14. At the young age of fourteen (14) I was cross-addicted to marijuana and beer. At that time I was curious about the "high" and had a need to get the courage to entertain my peers. The marijuana made me laugh a lot and I like that.

At sixteen (16) I started to drink liquor, added mescaline, stayed with marijuana and drank beer and threw in pills (speed) for good measure.

At seventeen (17) I added crack cocaine to my daily usage pattern. Eventually the other drugs could not compete with the ultimate high I felt I got from crack. I had this sense of conquering, a feeling that the world was at my command. For two (2) years this drug continued to satisfy my craving for all drugs and I become a loyal subject to freebasing.

At the age of nineteen (19) I gave birth to my first child. With my parents assistance a decision was made for me to place this child up for adoption. When I saw the child I immediately changed my mind about adoption. I contacted Catholic Social Services and stated that I had changed my mind about adoption, the child was placed in temporary foster care with a caucasian foster parent.

The child remained in foster care for fourteen (14) months in the same home. All the time the child was in foster care I kept thinking I would get my life together and reunite with my baby. I did make a serious effort to plan for the baby to come home. I started back using drugs and committed myself to a long term residential treatment program. When my child would come to visit me he was older, he didn't know me and he cried for the mother he knew. When these caring people asked me to let them raise my son I knew in my heart that it was the best solution for my young son and with a heavy heart; but a sense of knowing that I was doing the right thing, I agreed.

At the age of twenty-one (21) I gave birth to my second son. Between the births of my son I encountered my heaviest usage patterns. I was feeling so alone, empty and unwanted. I moved out of my mother's home and decided to go to Chicago and start a new life. What I found in Chicago was my old life in a new city; cocaine was there too. This child's father supplied me with drugs until he went to jail. My relatives were "straight" people, they neither understood addiction nor wanted it in their home. I was in the streets of Chicago pregnant, alone and addicted.

My father financed the trip back to Detroit returning me to my mother. That was his idea and what I returned to was my addiction. I had this second child in my addiction, left the hospital before the baby was released, I never returned to pick the child up. Protective Services took custody of the child and he was placed for adoption.

You have to understand that an addicted mind is not a rational, reasonable one. The thought of returning for my baby never occurred to me. I am not an uncaring person, I have a disease known as substance abuse and I've been very ill.

My family tried to understand, wanted to help me but they didn't know how and eventually I felt I was successful in showing them that they couldn't help me. They stopped trying.

After several treatments and delivering my baby at Hutzel Hospital, I learned of the Eleonore Hutzel Recovery Center (E.H.R.C.). This child was born out of my addiction, weighed one pound and eight ounces. The treatment program assisted me in understanding that I could rehabilitate and care for my child. While my baby struggled for survival I continued with treatment. By the time I had my son I was so tired. Tired of using, tired of being used; tired of being afraid of the unknown, tired of trying to be straight just to meet another crisis and slip back into the old familiar patterns; tired of being tired.

When I walked into the doors of the Eleonore Hutzel Recovery Center I came admitting my powerlessness over my addiction. I was ready to be taught what I needed to know to survive out here in the real world. I was ready to turn my will over to God and today I'm so grateful that He gave me this chance to seek and find the help I needed.

EHRC provides many services to women and their children. What the staff has taught me most is how to care, how to care about me. The staff cares for all of us but there's always the feeling of being cared for as a person.

Today, I live in Eleonore Hutzel East (domicile), with my baby that now weighs seven (7) pounds. I'm learning everyday how to cope with my addiction as a disease. I'm learning parenting and today I am a parent. EHRC had provided me with the necessary tools, it is my responsibility to use these tools and I plan to for the rest of my life. I have a family that I met in EHRC, they are also my support system.

On May 18, 1990, I will move forward from EHRC; the treatment will have ended. Although I'm nervous about the outside world I will be confident knowing that I have a place in EHRC that will always belong to me and I will never have to be alone again. All I have to do is contact my family.

I would like to close by saying peop.e do recover. No one including me would have thought that a person with my history would some day tell her story of sobriety to a group such as this. But here I am, drug free, happy, proud of my achievements, and grateful for all those who have dedicated their lives to helping those in need.

STATEMENT OF JOAN WALKER, ADMINISTRATOR, OFFICE OF SUBSTANCE ABUSE SERVICES, MICHIGAN DEPARTMENT OF PUBLIC HEALTH, LANSING, MI

Ms. WALKER. Thank you, Congressman Miller and members of the committee.

My name is Joan Walker and I am the Administrator for the State Office of Substance Abuse Services.

In the interest of time, I am going to not pick up on some of the statistics and so forth that I covered in my written testimony, I think that is in the packet now that you have. I will be focusing my comments specifically on what we are currently doing in Michigan, which is not enough, but also our planning for the future.

In Michigan, we have over 700 licensed substance abuse prevention and treatment programs and I am sorry to say that only 16 of these programs deal specifically or provide specialized services for prevention and treatment to addicted women, and only one of these to addicted pregnant addicts, the Hutzel Hospital which I believe you have looked at this morning.

I have included some statistics on the Eleonore Hutzel program at the end of the testimony in your packet. The program did not serve teen-agers at the time the statistics were collected, so you will not see any teen-age statistics reflected there. But I would like to point out that the highest percentage of admissions for women in the program were between the ages of 30 and 39.

As Administrator of the State Office of Substance Abuse Services, perhaps one of the most significant things I feel our office has done is to recognize that we can be far more effective in our efforts if we work closely with other state departments and other state agencies as we deal with this problem in a very comprehensive way.

We have joined with the Michigan Department of Public Health and the Office of Child and Youth Services to address the serious problem of maternal substance abuse and its impact on women.

Across the country, as you referenced earlier, Congressman, many states are proposing punitive responses with criminal sanctions to deal with this problem. In Michigan, our joint approach to maternal substance abuse and its related impact on infants tackles the problem at its earliest possible point. That is, assuring pregnant substance-abusing women that they receive prevention, education and treatment and their infants are assured of a safe and healthy family through the provision of parenting education.

It is our collective feeling that development of what we call a Sentinel System, or an early warning system, for mothers and infants at high risk is the very best chance for families where substance abuse is threatening the family survival. A Sentinel System is an approach that provides a single point for identification, tracking and follow-up of infants, and likewise their moms or their parents, who are at risk. The core of the system is support service through the first year of life and tracking system to assure the provision of needed services for both the infants and their moms.

A key component of this sentinel system will be the development of specific protocols to guide service delivery and tracking, including the criteria for referral to protective services and the assured

response from that system when appropriate. Such protocols are essential, particularly in the area of identification of infants where substance abuse during pregnancy is suspected. There is a wide range of symptoms which may be evident in an infant at birth and there is a wide range of criteria used to identify infants as drug exposed or addicted. Drug use includes many patterns that range from occasional or casual use to episodic use, to compulsive use associated with dependency. These differences have very significant differences or implications for the parenting capacity and the treatment kind of interventions. Through our joint efforts, we must recognize these differences when addressing the risks these mothers and infants are facing.

The problems of substance-abusing parents requires a comprehensive, yet highly focused, response. Families who are chronic polysubstance abusers have multiple legal, social and health problems. It seems obvious to state that all areas must be addressed, which is really the goal of the sentinel system. All too frequently, however—and I am sure you have seen this or heard this in your hearings around the country—this simple premise is ignored and services are fragmented and poorly coordinated.

I will be addressing one such approach that the Office of Substance Abuse Services is anxious to begin and hopefully will be beginning in the next couple of months. But before doing so, I want to stress that in addition to the importance of inter-agency and inter-departmental cooperation in addressing the multitude of needs for this special population, that all agencies must develop policy and funding to support the directions they are taking. Again, far too often, the lack of policy to support a program direction can be one of the key barriers to successful implementation of that program.

One of the policy directions that our office has been working very closely with the Michigan Department of Social Services on is to revise Medicaid coverage for substance abuse. We are hopeful that these proposed Medicaid changes will result in appropriate services being available to more recipients by providing federal financial participation for out-patient and intensive out-patient services. Currently, Medicaid only covers hospital-based services for people who are in life-threatening situations.

We are also exploring the possibility of federal financial participation for residential services for pregnant women and clients under the age of 21. Medicaid, as I said, has not covered non-hospital settings. I feel our efforts here in Michigan are well worth consideration at the federal level, and cannot stress enough the importance of getting Medicaid coverage to fund a full continuum of service from out-patient to day treatment to residential to hospital-based services, so that people can enter the system at the point which is most appropriate for them. It is also, I think, a significant savings, cost-wise.

Another policy decision that has been made by our office is to earmark money specifically to address this problem. Of the $15.9 million that Michigan will be receiving through the federal drug initiative, we are targeting one million to go for addicted moms, one million for women—addicted women, three million to go for children and 1.5 specifically for crack cocaine. So we are very seri-

ous about addressing this problem and backing it with financial resources.

Finally, along with the Michigan Department of Public Health and the Office of Child and Youth Services, we have just recently—this last week as a matter of fact—let out a joint RFP, Request for Proposal, for the development of new programming for a model family focused treatment program for chemically dependent women. This program will be targeted for Wayne County, which is the county that you are in now, primarily because of the number of addicted women who have been identified by Wayne County Protective Services who are at risk of losing their children due to their addiction. It is our hope that we will be able to replicate this program across the state. And to assist us in targeting that, we are hopeful we will be receiving some dollars that will allow us to do a prevalency study so we can target these dollars in the parts of the state where the need is greatest.

The model program must include participation of multiple organizations in the delivery of a comprehensive service for women, including pregnant and postpartum women, with family preservation as its focus. It will include the following components: pre-screening and assessment, day treatment and out-patient services, substance abuse prevention and education, domiciliary care for moms and their children, family counseling, child care and child treatment, medical care, outreach, after-care and evaluation. Additional services will include legal assistance, job and/or skill training, communicable diseases and any immunization programs, HIV counseling, assistance with the Michigan Department of Social Services program and services, assistance with meeting basic needs such as housing, infant support services, child and maternal health support, nutritional counseling, parenting classes, women's support groups, life skills, transportation and other support services, as appropriate.

We are interested in building on the concept of empowerment and integrating our approach with an approach proving to be pretty successful within the Office of Child and Youth Services called "Families First". This approach focuses on family strengths, provides an immediate response capability, is highly flexible in terms of the scheduling of hours and availability, small caseloads, intensive time limited intervention and services provided in the client's home and community. We are hopeful that this concept will be integrated into our discharge planning.

In summary, what we are doing in Michigan is recognizing the importance of inter-agency, inter-departmental cooperation, we are recognizing that as you move in these program areas, you need to have a strong policy base behind it and be willing to commit some dollars in that area. We certainly recognize that we have a lot of work before us, as I indicated with the initial statistics with our 16 programs out of the 700, but feel that we are in a very solid base for our future programming.

[Prepared statement of Joan Walker follows:]

PREPARED STATEMENT OF JOAN WALKER, ADMINISTRATOR FOR THE STATE OFFICE OF SUBSTANCE ABUSE SERVICES, MICHIGAN DEPARTMENT OF PUBLIC HEALTH, LANSING, MI

Good morning, my name is Joan Walker and I am the Administrator for the State Office of Substance Abuse Services. We are an autonomous agency within the Michigan Department of Public Health, charged with the responsibility for accomplishing the mandates of state and federal substance abuse services legislation. Our office's single largest function is to administer and coordinate all state and public funds for substance abuse treatment, rehabilitation and prevention services. We contract with 18 local coordinating agencies around the state for the delivery of substance abuse services within single and multi-county areas. These agencies in turn subcontract with the actual providers for program development, administration, prevention, evaluation, and planning.

It is a pleasure to have the opportunity to address congressional members of the Select Committee on Children, Youth and Families. I am particularly pleased with the committee's interest in substance abuse, specifically as it affects women, their children, their unborn fetus, their families, and the impact this dependency has on the community.

You have many excellent panelists who will be speaking with you today and extremely well qualified to speak to some of the data and research findings. I will be confining my comments to the question of what we are doing in Michigan to address the very pressing needs for this population.

STATEMENT OF PROBLEM

The National Institute of Drug Abuse estimates that as many as 10 out of every 100 pregnant women in the United States have used or are using cocaine, and each year, more than 300,000 infants are born with traces of some illegal drugs. No one knows how many are exposed to cocaine. Fetal exposure to alcohol is one of the leading known causes of mental retardation in the Western World. Treatment costs associated with such exposure total nearly one third of a billion dollars annually. Fetal alcohol syndrome occurs at the rate of 1 out of 750 cases, and 1 child out of 400 are born with the harmful consequences of alcohol exposure, learning disabilities, hyperactivity, and birth defects.

Hospitals in urban areas are reporting that between 10 and 40% of newborns have been exposed to drugs during pregnancy.

In Michigan our infant mortality rate for 1987 was 10.9 deaths for every 1000 live births, well above the national goal established for 1990 of 9 deaths per 1000. The infant mortality rate for blacks is more than double the white rate at 21.9. Many factors contribute to this high mortality rate, including the negative influence of substance abuse on pregnancy and perinatal mortality and morbidity. According to a 1989 Michigan Department of Public Health study, 43% of infants born at an urban Michigan hospital have been exposed to cocaine, heroin, or marijuana at some time during their pregnancy.

Along with increased mortality, infants born to substance abusing women are known to have increased incidence of asphyxia, prematurity, congenital malformations, abnormal heart and breathing patterns and drug withdrawal. Recent studies have also revealed that infants born to cocaine using mothers are at increased risk of sudden infant death syndrome.

The primary sources of AIDS among women of childbearing age are sharing of needles for intravenous drug use and sexual intercourse with an HIV infected intravenous drug user. The majority of Michigan's

pediatric AIDS cases are attributable to parental transmission. The overall result of these outcomes of substance abuse among women is unmeasured in terms of cost in both human and economic terms.

In Michigan there are only 16 licensed programs that provide specialized prevention or treatment services to women, but only one designed specifically for pregnant drug dependent women, the Eleanore Hutzel Recovery Program at Hutzel Hospital in Detroit. I have included statistics for Fiscal Year 1988-89 for the Hutzel Program in the appendix.

MICHIGAN'S RESPONSE

Sentinel System

As Administrator of the Office of Substance Abuse Services, perhaps one of the most significant things I feel our office has done is to recognize that we can be far more effective in our efforts if we work closely with other state offices and agencies interested and invested in dealing with this problem in a comprehensive way.

We have joined with the Michigan Department of Public Health and the Office and Children and Youth Services to address the serious problem of maternal substance abuse and its impact on women. Across the

country, as you know, many are proposing punitive responses and criminal sanctions as an answer to this problem. In Michigan, our joint approach to maternal substance abuse and its related impact on infants tackles the problem at the earliest possible point, that is, assuring that pregnant substance abusing women receive preventive education and treatment, and that their infants are assured of a safe and healthy family through the provision of parenting education.

It is our collective feeling that the development of what we call a Sentinel System for mothers and infants at high risk is the best chance for families where substance abuse is threatening family survival. A Sentinel System is an approach that provides a single point for identification, tracking, and follow-up for infants at risk. The core of the system is support services through the first year of life and tracking system to assure the provision of needed services.

A key component of the sentinel system will be specific protocols to guide service delivery and tracking, including the criteria for referral to child protective services, and an assured response. Such protocols are essential, particularly in the area of identification of infants where substance abuse during pregnancy is suspected. There are a wide

range of symptoms which may be evident in an infant at birth and there is a wide range of criteria used to identify infants as "drug exposed or addicted." Drug use includes many patterns that range from occasional casual use of low doses, to episodic use, to compulsive use associated with dependency. These differences have different implications for parenting capacity and treatment interventions. Through our joint efforts, we must recognize these differences while addressing the risks mothers and infants are facing.

The problems of substance abusing parents require a comprehensive yet highly focused response. Families who are chronic polysubstance abusers have multiple legal, social and health problems. It seems obvious to state that all areas must be addressed which is the goal of the Sentinel System. All too frequently, however, this simple premise has been ignored, with services being fragmented and poorly coordinated.

I will be addressing one such approach that the Office of Substance Abuse Services will be funding, but before doing so, want to stress that in addition to the importance of interagency and department cooperation in addressing the multitude of needs of this special population, each

agency must develop policy and funding to support this direction. Again, far too often, the lack of policy to support program direction can be one of the key barriers to successful implementation.

Medicaid as a Support to Servicing Addicted Women

The Office of Substance Abuse Services has also been working closely with the Michigan Department of Social Services to revise Medicaid substance abuse coverage. We are hopeful that these proposed Medicaid changes will result in appropriate services being available to more recipients by providing federal financial participation for outpatient counseling and intensive outpatient services. We are also exploring the possibility of federal financial participation for residential services for pregnant women and clients under the age of 21. Medicaid has not covered substance abuse treatment in non-hospital settings. This has resulted in many recipients entering expensive hospital based programs which are more costly, often inappropriate interventions. I feel our efforts here in Michigan are well worth serious consideration at the federal level, and cannot stress enough the importance of federal financial participation for residential care.

Another policy decision made by the Office of Substance Abuse Services has been to earmark money specifically for the development of new programming for addicted women. Of the 15.9M dollars Michigan is scheduled to receive under the new block grant funding, we have earmarked 1M for addicted moms, 1M for women's prevention and treatment programs, 1.5M for crack cocaine treatment and 3M for youth prevention and treatment. We are very serious about our commitment.

Joint Programming Initiatives

Finally, along with the Michigan Department of Public Health and the Office of Children and Youth Services, we have just let out an RFP for the development of new programming for a model family focused treatment program for chemically dependent women. This program is targeted for Wayne County, primarily because of the number of addicted women who have been identified in Wayne County who have been referred to protective services and are at risk of loosing their children due to their addiction. It is our hopes to replicate this program throughout the state. Because resources are limited, we are hopeful to get funding to conduct a prevalency study so that the dollars can be targeted to those areas of the state where the need is greatest.

This model program must include participation of multiple organizations in the delivery of comprehensive services for women, including pregnant and postpartum women, with family preservation as the focus. It will include the following components: pre-screening and assessment, day treatment and outpatient services, substance abuse prevention and education, domiciliary care for moms and their children, family counseling, child care and child treatment, medical care, outreach, aftercare and evaluation. Additional services would assure legal assistance, job and/or skill training, communicable disease and immunization programming, HIV counseling, assistance with the Michigan Department of Social Services programs and services, assistance with meeting basic needs such as housing, infant support services, child and maternal health support, nutritional counseling, parenting classes, women's support groups, life skills, transportation and other support services, as appropriate.

We are interested in building on the concept of empowerment and integrating our approach with an approach proving to be very successful within the Office of Children and Youth Services called Families First. This approach focuses on family strengths, provides

immediate response, highly flexible scheduling, i.e. 24 hour 7 day/ week availability, small caseloads, intensive time limited intervention, and services provided in the client's home and community. We are hopeful that this concept can be integrated into our discharge planning.

In summary, what we are doing in Michigan is recognizing the importance of interagency interdepartmental efforts in order to be effective, we are recognizing that these efforts must be based on well thought out policy and have dollars designated to assure implementation. We have lots of work before us, but I believe we are building a solid base for future programming.

Thank you for the opportunity to speak before you today.

ELEANORE HUTZEL RECOVERY PROGRAM

PREGNANT ADDICTS

In regards to the issue of pregnant addicts, Michigan has only one program which is designed to specifically deal with the issue of pregnant addicts, Eleanore Hutzel Recovery Program at Hutzel Hospital in Detroit. Due to the insurance liability issue, there are very few obstetricians in the state which will knowingly deal with the pregnant addict. Most will refer a female who is found to be addicted to the Eleanore Hutzel program. The following are statistics for the 1988-89 fiscal year on that program.

Primary Substance Abuse Problem Upon Admission

Substance	Frequency	Percentage
None	1	0.2%
Alcohol	61	9.4%
Heroin	92	14.1%
Other Opiates	18	2.8%
Tranquilizers	1	0.2%
Amphetamines	2	0.3%
Cocaine	171	26.3%
Crack Cocaine	289	44.4%
Marijuana/Hashish	14	2.2%
Missing Observations	2	0.3%
Totals	651	100.0%

Age Upon Admission

Age	Frequency	Percentage
18 - 20	21	3.2%
21 - 25	170	26.1%
26 - 29	185	28.4%
30 - 39	248	38.1%
40 - 54	7	3.8%
Missing Observations	2	0.3%
Totals	651	100.0%

Race

Race	Frequency	Percentage
White	70	10.8%
Black	573	88.0%
Hispanic	2	0.3%
Unknown/Refused	4	0.6%
Missing Observations	2	0.3%
Totals	651	100.0%

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Chairman MILLER. Thank you. I think what we might do is, if members have questions specifically of Joan, they ought to ask them so that she will be able to keep her other parts of her schedule.

This is a rather ambitious program that you outline and I commend you for it. One of the items that you have mentioned, and I do not know if you can elaborate on it a little bit more, but in our discussions with people in putting together this series of hearings, and as some people have already testified, have constantly testified to the fact that drug treatment and prenatal care kind of missed one another in the system, that they may even be in the same building, the same hospital or certainly potential clients are moving through this system, but there just is not that kind of discussion or coordination taking place, and as a result of that, we are missing a rather significant opportunity to get ahold of these women at a time when there is some evidence suggesting that they are more amenable to this kind of change.

I just wondered if you might elaborate a little bit on what you are doing.

Ms. WALKER. Well that is really the basis of the sentinel system that I referred to in the testimony. This is a system which will, rather than Protective Service being the point of entry for a lot of these women who are identified substance-abusing pregnant women, the point of entry will really be through the public health system who will provide the kind of supports that you are referring to and can do a comprehensive assessment in terms of additional needed services.

Additionally, the Department of Public Health and our office have recognized the importance of the two of us merging our programming far more than we have in the past.

So that is really the cornerstone of the sentinel system.

Chairman MILLER. Am I to assume also that the message you are sending to this table is that Medicaid is somewhat of an impediment in that they will only deal with intensive detox but they will not allow you to do these auxiliary support services, in terms of reimbursement?

Ms. WALKER. Exactly. What we are hoping to do with our state Medicaid office is we are doing some trading of dollars. Currently we have had a state Medicaid program where we have included some residential services in our coverage, but we are now indicating—we are sort of taking those dollars and saying if we can get federal financial participation in the out-patient and intensive day treatment programs, we are willing to fund this residential only out of state dollars when it is appropriate. So it is a switching of dollars, but in essence we are feeling that we can provide services to far more people, and appropriate service. The intention was not a cost-saving intention in doing this. We truly believed that there are a lot of people that are denied appropriate interventions because of the way the financial reimbursements are set up.

Chairman MILLER. Congressman Levin.

Mr. LEVIN. Just a bit more on that before you leave, your reference to revising substance abuse coverage. The state is now using the Medicaid coverage to its limits? In other words, the federal guidelines for Medicaid provide for reimbursement up to a certain

point. Some states do not utilize the Medicaid reimbursement up to the limit.

Ms. WALKER. Oh, yes.

Mr. LEVIN. In this area in Michigan there is utilization of Medicaid as fully as possible relating to drug addiction?

Ms. WALKER. Right, but only in hospital-based settings for life-threatening situations.

Mr. LEVIN. That is the federal regulation?

Ms. WALKER. Right.

Mr. LEVIN. In Michigan it is being utilized as fully as possible.

Ms. WALKER. That is correct, yes.

Mr. LEVIN. So when you are talking about revising Medicaid substance abuse coverage, there is not any way for Michigan to actually revise it unilaterally, you are talking, as you said, about trading off——

Ms. WALKER. Well this is through a waiver, we are getting a waiver.

Mr. LEVIN. I see.

Ms. WALKER. It is not in the federal regulations, as I understand it, but there are ways to obtain waivers and we have gotten the support from our state Medicaid office to seek this waiver from the feds. But it is a long process and if the federal policy differed on this issue, it would certainly assist states considerably. We have been working on this for about eight-nine months.

Mr. LEVIN. Thank you.

Chairman MILLER. Congressman Holloway.

Mr. HOLLOWAY. In our interviewing witnesses for this hearing, staff has told me that there was money up in Lansing, because of excess regulation, some of the grassroots people do not seem to be able to receive that money. Can you tell us a little bit more about that? Is there money at Lansing or——

Ms. WALKER. Well we have a system where the state agency passes dollars through to 18 coordinating agencies around the state who are responsible for the identification of needs in that area through a public hearing process and so forth. So that I am sure there are many groups—of the 700 substance abuse prevention and treatment agencies who are licensed by our office, only about 300 of those receive funding, so there are a lot of people out there I am sure who are not part of the provider network that is being funded, but I think we will have to have many, many, many more dollars for us to be able to assure all providers are being funded for their services.

So without knowing a little bit more about what the complaint was, it is hard to address that.

Mr. HOLLOWAY. I want to go back just a minute to what Congressman Levin was speaking about, since Medicaid is a state run program.

Are you basically telling us that you are handicapped somewhat or that you need federal mandates or regulations, to ease restrictive plicies—I mean you could change them at the state level, but it is very difficult, am I right?

Ms. WALKER. It is a lengthy process and we have to work with the feds to do that around this waiver process. It seems to me that substance abuse is really a very serious problem before us and if

the policy at the federal level cannot demonstrate support towards helping states address that problem in terms of recognizing it as a medical problem that needs some assistance in terms of coverage for out-patient, day treatment, residential and hospital-based care, it is like we hear a lot of verbiage coming from Washington in terms of being concerned and interested in the problem, but what I am saying is I think you have some policies in Washington that inhibit and make it difficult for states to do what you would like us to.

Mr. HOLLOWAY. Are you hopeful or do you see possibilities of changes? I think the nation varies a whole lot. I am sure there are a whole lot of differences in different regions, I know there are in my district. It is hard for me to completely relate to this hearing in Detroit because my district is basically rural. Even though there are drug problems throughout the nation and there are drug problems in my district, I do not see a large crack problem in talking to the hospitals in my district. They do not seem to have the problems there that the inner-city does. Are you hopeful that there is change that will happen at the state level, or is it going to just absolutely have to come from the federal government?

Ms. WALKER. Well I think if the federal government can make some policy decisions that support states in being able to deal with the substance abuse problems in the states, I think it will be a tremendous help. What I am saying is I have appreciated, first of all, our state lending an interested ear towards this problem and working with us in terms of working with the federal government around this waiver, so that we can do some creative things here. I think we can do it here in Michigan through a waiver, I am saying that the waiver process is arduous and it takes a lot of time and that is a barrier. And if you can assist us at the federal level in removing that, it would be of assistance really across the country.

Mr. HOLLOWAY. Thank you.

Mr. DURBIN. The Chairman said that I was to follow Mr. Holloway here. I find it interesting when it comes to Medicaid that we occasionally at the federal level create incentives for states to move forward in areas where they have not shown the initiative on their own, particularly in areas like prenatal care and the coverage for poor women and poor families. It seems to me that our incentive that we are offering the state is we will provide money if you will cover certain people, we will provide our 50 percent share. And although that provides pressure on governors who might not otherwise want to move in that area, it is still generally a voluntary decision on their part as to whether they will extend the program or how they will extend it. There are other areas where we just positively mandate it, say you will cover a certain amount and be prepared to pay for it. And in those instances, many governors scream bloody murder, that we are in fact mandating programs that cost them dearly in terms of their state resources, that they might not choose to fund if they were on their own.

Where are you coming down on this? Are you suggesting a permissive approach to it, to allow states to do this, as the best first step?

Ms. WALKER. You mean would I recommend it be a mandated or an optional benefit at the state level? Well I have not spoken with

our governor about this, so I am winging it a bit, but I would say that our governor is very concerned and interested in this problem and I am speaking for myself now and I would say that I think he would be interested in looking at this as a mandated benefit. Now I will need to touch base on that issue, but clearly in Michigan we are moving in that direction anyway, so I would have to assume that he is supportive of that direction and would not be one of the governors raising that as an objection. I know what you are saying though, when the feds mandate certain coverage that is problematic in other states.

Mr. DURBIN. And expensive.

Ms. WALKER. Yes.

Mr. DURBIN. Regardless of the merits, it is just a question of the philosophy, the governors would like to make their own decisions and use the federal money as they see fit, and we of course would like to make sure it is spent in certain directions.

Ms. WALKER. I guess I would also say I think it is going to be more expensive not to do this.

Mr. DURBIN. I agree with that. I think we are in a state of pure anarchy here with the chairman gone, but I thank you for joining us and maybe we ought to proceed with the witnesses.

Should I assume the responsibility here?

Mr. HOLLOWAY. I do not think I am allowed to.

Mr. DURBIN. I believe Dr. Marilyn Poland is next.

STATEMENT OF DR. MARILYN L. POLAND, ASSOCIATE PROFESSOR, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, WAYNE STATE UNIVERSITY MEDICAL SCHOOL, DETROIT, MI

Dr. POLAND. I would like to thank you for the chance to testify before your committee.

I am a medical anthropologist in the OB–GYN Department at Wayne State University and here at Hutzel Hospital. For the past seven years, I have been conducting surveys of high risk, low income pregnant women to find out why many do not receive adequate amounts of high-quality prenatal care and why so many have low birth weight babies. One of our surveys examined over 600 women in five hospitals in Detroit and Wayne County, Michigan. We interviewed these women at length two to five days after they gave birth. This was not a random sample and the numbers and percentages do not represent all pregnant women. We chose only women who had received little or no prenatal care or had received care in publicly-funded clinics. Fifty-eight percent of the women were black, 42 percent were white. For the purposes of this hearing, I will present two conclusions from the survey.

The first is that there are adverse effects of substance use on seeking prenatal care and on birth weight. The second is that pregnancy presents a unique chance for us to alter the effects of substance use on the infant and on the mother as well.

First, we examined the effects of chemical dependency on prenatal care and birth weight. For this analysis, we divided the 600 women into four groups; those who were not chemically dependent, those addicted to cigarettes only, those who used small amounts of alcohol or drugs and those dependent on moderate to large

amounts of drugs or alcohol. Many women in the last two groups also used cigarettes.

One of our major findings was that chemical dependency increased the risk of having a low birth weight infant. While less than 13 percent of the babies in the group who were not chemically dependent were low birth weight, or less than 5.5 pounds, 31 percent of the babies born to mothers who used moderate to heavy amounts of drugs and alcohol were low birth weight. The odds of having a low birth weight infant for a woman who uses moderate to large amounts of drugs or alcohol is more than three times that of a woman who uses no substances.

Other factors as well were linked with chemical dependency. Women who were more severely chemically dependent gained less weight over pregnancy and delivered on average one and one half weeks earlier.

Overall, 18 percent of the women in the survey planned this pregnancy. Only eight percent of the heavy substance users planned to become pregnant. Initially 76 percent of the heavy user group did not want the pregnancy, although by delivery 94 percent wanted their babies. One corollary of the combination of chemical dependency, the stressors they encountered and the unplanned and unwanted pregnancy was a significantly higher prevalence of depression in these women and a lack of hope about their future.

There was also a correlation between degree of chemical dependency and the amount and quality of prenatal care women received. Chemically dependent women received less care and were more likely to seek care at emergency rooms and walk-in clinics, most of which are not equipped to provide prenatal care. Thus, those at greatest risk of having a low birth weight infant received the least medical attention. This is contrary to public health practice. There were several reasons for this paradox.

First, 20 percent of the women in the highest substance use group sought no prenatal care at all. The reasons they gave included not wanting the pregnancy and therefore not viewing medical care as important, and fear of a discovery of their chemical dependency by medical professionals. One woman's attitude was typical, "They think I am not human because I am a drug user", she said. Many had problems finding a physician or a clinic that would see them. They used emergency rooms and walk-in clinics because they could be seen by a doctor without having to disclose their chemical dependency or because it was the only place they felt that would not turn them away.

Thus, chemical dependency during pregnancy is linked with depression, isolation from health institutions established to help and it produces smaller babies.

The second question we asked concerns the effects of pregnancy on chemical dependency.

We found, as have others, that pregnancy has a dramatic effect on reducing substance use in many women. Before pregnancy, 53 percent of the women smoked one or more cigarettes a day. During pregnancy, 11 percent of the women who smoked stopped and an additional 10 percent reduced their amount of smoking. Forty-nine percent of the sample had from one to 56 drinks a week before pregnancy. By the last three months of pregnancy, only 17 percent

used alcohol and of these most had reduced the amount of consumption. Before pregnancy, 33 percent of the women used street drugs, during pregnancy 16 percent reported using drugs. However, for those 16 percent, many reduced the amount of drugs or used drugs they felt would be less harmful to the fetus.

This reduction in substance abuse occurred for two reasons. First, many of our mothers were concerned about the health of their babies. As one woman said, "I could abuse myself, but not my baby." Second, there was continuous concern and pressure from family, friends and professionals to reduce the use of alcohol and drugs. One woman, whose boyfriend was a drug dealer, was pressured by him to reduce her crack cocaine habit, so "his" baby would be born healthy.

Thus, pregnancy and concern for the fetus prompts many women to reduce or discontinue use of cigarettes, alcohol and illicit drugs by personal means. Some of the women are also prompted by pregnancy to seek treatment for drug addiction. For the 70 women in the heavy substance use group, 64 percent used illicit drugs. Thirteen percent of these women reduced drug use on their own. Thirty-five percent sought treatment at Eleonore Hutzel Recovery Center. Two women who registered for therapy were unable to complete the three preliminary visits required for entry. As one woman described it, "My drug habit was just too strong." Most of the others who did not enter treatment were discouraged by the long wait for an initial appointment and two women did not want methadone treatment as they believed it was more harmful to their babies than heroin.

We and other researchers have documented the serious effects of chemical dependency, especially alcohol and illicit drugs, on seeking prenatal care and on birth weight. We have also found that most chemically dependent women are concerned for their babies and motivated to reduce their use of harmful substances and to seek therapy.

While chemical dependency during pregnancy is certainly a tragedy, it affords us an chance to reach some of the victims. I order to do this, we need more accessible prenatal care and drug treatment programs uniquely suited to the needs of this disadvantaged population. It is not enough to merely expand drug treatment programs. We also need to make prenatal care clinics more accessible than walk-in clinics and emergency rooms. This will allow us to identify women in need of drug treatment and encourage their enrollment in treatment programs that do not end with delivery. Such linked prenatal care and substance abuse programs are not only important for the mother and child, but for her future children as well.

Chairman MILLER. Thank you.

[Prepared statement of Marilyn Poland, Ph.D., R.N., follows:]

Prepared Statement of Marilyn L. Poland, Ph.D., R.N., Joel Ager, Ph.D., Department of Obstetrics/Gynecology, Wayne State University Medical School, Detroit, MI

I would like to thank you for the opportunity to testify before this committee.

I am a medical anthropologist in the Department of Obstetrics and Gynecology at Wayne State University and here at Hutzel Hospital. For the past seven years, I have conducted surveys of high risk, low income, primarily medicaid-eligible pregnant women, in Detroit and its surrounding county to identify reasons why women do not receive adequate amounts of high quality prenatal care, and why so many have low birth weight babies. One of our surveys examined over six hundred women in five hospitals in Detroit and Wayne County, Michigan. We interviewed these women at length two to five days after they gave birth. This was NOT a random sample and the numbers and percentages do not represent all pregnant women. We chose only women who had received little or no prenatal care or had received care in publically-funded clinics. Fifty-eight percent of the women were black and forty-two percent were white. For the purposes of this hearing, I will present two conclusions from this survey. The first is that there are adverse effects of substance use on pregnancy, prenatal care and birthweight. The second is that pregnancy presents a unique opportunity for us to alter the effects of substance use on the infant and on the mother as well. I will begin by describing the adverse effects and then discuss the unique opportunity pregnancy affords us.

First, we examined the effects of chemical dependency on pregnancy.

prenatal care, and birthweight. For this analysis, we divided the six hundred women into four groups: those who were not chemically dependent, those addicted to cigarettes only, those who used small amounts of alcohol or drugs, and those dependent on moderate to large amounts of drugs or alcohol. Many women in the last two groups also used cigarettes.

One of our major findings was that chemical dependency increased the risk of having a low birthweight infant. While less than thirteen percent of babies in the group who were not chemically dependent were low birth weight (or less than 5½ pounds), thirty-one percent of the babies born to mothers who used moderate to heavy amounts of drugs and alcohol were low birth weight. The odds of having a low-birth weight infant for a woman who uses moderate to large amounts of drugs or alcohol is more than three times that of a woman who uses no substances. Other factors as well were associated with chemical dependency. Women who were more severely chemically dependent, gained significantly less weight over pregnancy, and delivered, on average, 1½ weeks earlier. There was also considerably more stress in their lives. They moved more often--an average of six times during pregnancy--although only three percent were homeless at the time of the interview. They have a harder time finding safe housing, paying the rent and utilities and they receive less emotional and tangible support from the baby's father, their family, and friends. They are more likely to be physically abused by their male partner. Overall, eighteen percent of the women in the survey planned this pregnancy. Only eight percent of the heavy substance users planned to become pregnant. Initially, seventy-six percent of the heavy user group did not want the pregnancy, although by delivery, ninety-four percent wanted their babies. One corrolary of the combination of chemical dependency, the stressors they

encountered, and the unplanned/unwanted pregnancy, was a significantly higher prevalence of depression in these women and a lack of hope about the future. Fewer of these women felt their babies would bring any happiness to their families.

There was also a significant correlation between degree of chemical dependency and the amount and quality of prenatal care the women received. Women not chemically dependent received more prenatal care at high quality public health and hospital clinics. Chemically dependent women, by contrast, received less care, and were more likely to obtain much of that care at emergency rooms and walk-in clinics, most of which are not equipped to provide prenatal care. Thus, those at greatest risk of having a low birth weight infant received the least medical attention. This is contrary to public health practice. There were several reasons for this paradox. First, twenty percent of the women in the highest substance use group sought no prenatal care at all. The reasons they gave included: not wanting the pregnancy and therefore not viewing medical care as important, fear of the discovery of their chemical dependency by medical professionals, and negative experiences with unsympathetic health and social service personnel. One woman's attitude was typical, "They think I'm not human because I'm a drug user", she said. This group of women also suspected they were pregnant much later in pregnancy than the others and therefore entered care later. In addition, many had problems finding a physician or a clinic that would see them. Many used the emergency rooms and walk-in clinics because they could be seen by a doctor without having to disclose their chemical dependency or because it was the only place they felt that would not turn them away.

Finally, I want to mention that we did not find any differences among

the four groups of women in education or the amount of health insurance they had. Thus, these factors did not contribute to their amount of prenatal care or to birthweight. There were two differences by racial/ethnic background. White women were significantly more likely to smoke during pregnancy and black women had lower incomes.

Thus, chemical dependency during pregnancy is associated with a stressful lifestyle, depression, isolation from family, friends, and health institutions established to help women, as well as producing smaller babies.

The second question we asked concerned the effects of pregnancy on chemical dependency.

We found, as have others, that pregnancy has a dramatic effect on reducing substance use. Before pregnancy, fifty-three percent of the women smoked one or more cigarettes per day. During pregnancy, eleven percent of the women who smoked, stopped, and an additional ten percent reduced their amount of smoking. Forty-nine percent of the sample had from one to fifty-six drinks a week before pregnancy. By the last three months of pregnancy, only seventeen percent used alcohol and of these, most had reduced the amount of consumption. Before pregnancy, thirty-three percent of the women had ever used street drugs. During pregnancy, sixteen percent continued to use drugs. However, for those sixteen percent, many reduced the amount of drugs, or used drugs they felt would be less harmful to the fetus.

This reduction in substance use occurred for two reasons. First, many of our mothers were concerned about the health of their babies. As one woman said, "I could abuse myself, but not my baby." Second, there was continuous concern and pressure from family, friends, and professionals to reduce the use of alcohol and drugs. One woman, whose boyfriend was a drug dealer, was

pressured by him to reduce her crack cocaine habit so "his" baby would be born healthy.

Thus, pregnancy and concern for the fetus prompts many women to reduce or discontinue use of cigarettes, alcohol, and illicit drugs by personal means. Some of the women are also prompted by pregnancy to seek treatment for drug addiction. For the seventy women in the heavy substance use group, sixty-four percent used illicit drugs. Thirteen percent of these women reduced drug use on their own. Thirty-five percent sought treatment at Eleonore Hutzel Recovery Center. Of these thirty-five percent, one-half continued in therapy until delivery. Two women who registered for therapy were unable to complete the three preliminary visits required for entry into the program. As one woman described it, "my drug habit was too strong." Most of the others who did not enter treatment were discouraged by the long wait for an initial appointment, and two women did not want methadone treatment as they believed it was more harmful to their babies than heroin.

We and other researchers have documented the serious effects of chemical dependency, especially alcohol and illicit drugs, on pregnancy, on prenatal care, and on birthweight. We have also found that most chemically dependent women are concerned for their babies and motivated to reduce their use of harmful substances and to seek therapy.

While chemical dependency during pregnancy is certainly a tragedy, it affords us an opportunity to reach some of the victims. In order to do this, we need more accessible prenatal care and drug treatment programs uniquely suited to the needs of this disadvantaged population. It is not enough to merely expand drug treatment programs. We need to make prenatal care clinics more accessible than walk-in clinics and emergency rooms. This will allow us to identify women in need of chemically dependent treatment and encourage their enrollment in treatment programs that do not end with delivery. Such linked prenatal care and substance abuse programs are not only important for the mother and child, but for her future children as well.

STATEMENT OF WILLIAM T. ATKINS, DIRECTOR, ILLINOIS DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE, ACOMPANIED BY WILLIAM G. HALL, ASSOCIATE DIRECTOR, ILLINOIS DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE, DETROIT, MI

Mr. ATKINS. Chairman Miller, distinguished members of the select committee, I want to thank you for providing the opportunity to speak with you today. I am Bill Atkins, the Director of the Department of Alcoholism and Substance Abuse. We are the single state authority charged with the development and implementation of all substance abuse treatment and prevention programs in Illinois.

No issue is more important to me than the prevention of drug and alcohol exposure to unborn babies and thus services for their pregnant mothers and other child-bearing age women. And I agree that incarceration is not the correct approach. We have been working for more than two years with Governor James Thompson, Illinois' legislature and our sister agencies, to develop a comprehensive continuum of care for these women.

I want to thank the select committee and the U.S. Congress for its concern about this problem and its support for the development of special services through the increased funding of the alcohol, drug and mental health block grants. Without that funding and without Governor Thompson's drug-free Illinois initiative, none of what I am about to describe would have been possible.

I am proud too of the continuum of care for child-bearing age women, the pregnant woman and the post-partum woman that we are building in Illinois. From primary prevention through intensive residential services.

It is working because of the leadership from the top, from the Governor and his human service agency directors. And it works because it recruits women from all referral sources and through our own aggressive outreach programs.

We know it works because we have outcome evaluations that verify that.

Two early demonstration projects funded by the Department deserve special mention. They have provided the model and the direction for our current efforts.

Both are three-year demonstration projects which considered the use of a combination of treatment and parenting support in a therapeutic environment where children can stay with their mothers.

One program in rural down-state Illinois, which can take four families at a time, has a success rate of 79 percent. Of the 15 women who completed the program during the evaluation, all are sober, all have jobs or are in college and 23 of their 24 children are permanently in the mother's custody. Many of these women had a life-long history of substance abuse treatment failures in male-dominated settings.

The other site, drawing clients from Chicago and its suburbs, has experienced similar gratifying results. Eighty-one percent of those completing the program are doing well, which means 63 women in three years have stayed sober, have their children and are produc-

tive citizens. As you might suspect, many of these women were public aid recipients prior to this.

The treatment programs I describe are not just beneficial for the client. For example, our research has shown a dramatic savings in medical expenditures simply by treating alcoholism and other drug abuse.

We found several years ago in a two-year study of Medicaid clients, using a matched control group, that Illinois saved half a million dollars in medical costs for only 176 clients. The lower costs continued through the life of the study. The clients and other members of the family used fewer medical services. The cost of treatment through the community-based DASA funded system, was one-third the cost of similar care in hospitals, which has provided additional savings over the half a million dollars.

In Illinois today, as a result of that study, substance abuse services to Medicaid eligible women are reimbursed to community-based agencies, except residential services which are not collecting federal reimbursement because HCFA, the Health Care Financing Administration, still declares them institutes for mental diseases, which means they are ineligible for reimbursement.

Let me briefly describe the elements of the continuum of services available to pregnant and post-partum women in Illinois.

Much of our prevention effort is centered around a program called "Drug Free Families with a Future", which is our name for the integration of the infant mortality network and the drug and alcohol treatment and prevention system. We have placed more than 20 prevention specialists in high-risk communities throughout Illinois this year. The role of these specialists is to engage social and health care workers in the "Drug Free Families with a Future" networks and their clients, concentrating on two major strategies; namely, information and public education on alcohol and other drug use and skills-building and community training.

DASA's prevention specialists are assisting "Families with a Future" providers in developing and enhancing a detailed work plan. The overall focus is that alcohol and other drugs are harmful to potential parents, the fetus and to growing children. This public education plan is modeled after a project called I-PASS, a well-evaluated perinatal addiction public education campaign targeting pregnant women under 20 years of age in Chicago's Grand Boulevard area.

These "Drug Free Family" sites will be specifically targeted with in-depth skills building training. There are three specific types of training which we are offering:

Baseline training, which provides a complete experiential basis for understanding alcohol and other drugs and their effects on the family;

In-depth skills building training on parenting, using "Preparing for the drug-free years", "Effective black parenting" and "Los Ninos" which is designed for the Hispanic community;

Intervention training of one to two days to learn assessment and referral practices.

Training takes place in the following settings in the community:

Each social service agency that feeds into the site;

Churches located at each site;

Each school building in the target areas;

And businesses located within each community area.

The "Drug Free Families with a Future" programs also serve as a referral source for the next step in our continuum, integrated family intervention teams, or as we call them, IFIT. The goal of IFIT is simple, get the mother sober and clean, get her to deliver a healthy drug-free baby and keep her family together. The core of the teams are outreach workers and case managers.

Outreach workers find pregnant women and new mothers by doing grassroots outreach. They visit jails, clinics, laundromats, et cetera, or they get referrals from child welfare agencies, churches and other local institutions. They track the mothers and provide transportation and other support services as needed.

The case managers provide linkage to traditional community providers and state agency personnel; child welfare, public aid, public health and vocational rehabilitation. Each agency contributes staff to the IFIT team to help develop a plan for the young mother. Besides substance abuse services, she may require prenatal and postnatal care, housing, parenting skills, job training, et cetera.

Eligibility continues until the mother is one year old or until the mother is free of drugs and alcohol—I am sorry, until the baby is one year old and the mother is free of drugs and alcohol. Babies can also be referred for developmental services if needed. Follow-up services help the mother stay clean and ensure that her baby receives whatever health and developmental services are required.

Earlier I mentioned the importance of cooperative efforts among sister agencies in Illinois who are concerned about substance abuse among women. One fine example of this sort of cooperation is "Project Safe", a program jointly developed by the Department of Alcoholism and Substance Abuse and the Department of Children and Family Services.

This award-winning/nationally recognized program combines intensive out-patient treatment with parent training for mothers found to be neglectful by DCFS. These two service elements are supported by outreach workers who provide frequent assistance to clients in their homes. Women participate in special groups which focus on women's issues and they attend self-help meetings regularly.

The model is designed to achieve specific, measurable changes in the mothers' functioning and parenting behavior.

Evaluation of this project shows a significant decrease in the abuse of alcohol and other drugs, improved attitudes toward recovery from addiction, significant reductions in anxiety. And the program has experienced a family reunification rate of 51 percent compared to either 29.6 percent in a control group of substance-abusing women or 40 percent in a control group of non-using women. And an 80 percent treatment completion rate compared with 40 percent in the typical setting.

In concluding my remarks, I would like to briefly tell you about three special projects underway in Illinois which will provide the entire continuum of care for substance-abusing pregnant women with their children. The continuum ranges in scope from social setting detox to halfway house and out-patient programs.

As I mentioned earlier, there are many problems associated with the treatment of this population, some clinical and some logistical, primarily because of the existing children and the need to provide care for them, a problem which often complicates the task. That task, of course, is to assist with recovery of the mother, the protection of the fetus and the preservation of the family.

First is a new women's treatment center in Chicago being developed in a defaulted west side community hospital, to provide services for addicted pregnant women with their children from throughout Illinois, offering a full continuum of treatment:

Medical detoxification; Residential rehabilitation with capacity for children to stay with their mothers during treatment; Out-patient treatment; Intensive out-patient treatment; Halfway house and recovery home services; and Prevention and training services.

Medical, social, remedial education and vocation support services will be delivered on-site through an array of inter-agency agreements at the state and local levels.

Secondly, the Chicago Clergy Association has in the past two months opened a maternal addiction center to provide treatment ranging from social setting detox to long-term—depending on the length of the pregnancy—residential rehab for pregnant abusers focusing on the needs of the woman and her unborn children. We have 19 beds for detoxification and 22 for residential rehabilitation.

And third and finally, a joint project involving the Department of Alcoholism and Substance Abuse and the Department of Children and Family Services at the Columbus/Maryville emergency receiving shelter for abused and neglected children is to be expanded by 50 to 60 beds to accommodate postpartum women and their drug-exposed new-born babies. In January of this year, Illinois implemented a law that provides for the protection of any new-born with a controlled substance in its blood or urine.

The focus of this program is on family preservation and on rehabilitation of the postpartum female. The facility, currently under renovation, is being designed to accommodate mother and children together in a comprehensive rehabilitation program.

The Department of Alcoholism's primary role is to concentrate on the mother as a pregnant substance-abuse client and to integrate programs with DCFS and other human service agencies regarding infants, siblings and families in general.

With innovation and comprehensive programs like these, we are filling gaps which exist when it comes to the all important treatment needs of this very special population.

Again, simply put, the ultimate goal for all of our prevention, intervention and treatment efforts, especially regarding addicted pregnant women with children, is to help her deliver a healthy baby, get the mother clean, off of drugs and alcohol and keep her family together whenever that is possible and appropriate.

Thank you very much.

Chairman MILLER. Thank you very much.

If we could ask you, Mr. Atkins, if you would move over one seat, we can hear from Dr. Reed.

If Hutzel Hospital knew it was going to get all this attention it would have built a larger stage, but what the heck.

Welcome to the committee and we look forward to your testimony.

[Prepared statement of William T. Atkins follows:]

Prepared Statement of William T. Atkins, Director, Illinois Department of Alcoholism and Substance Abuse, Detroit MI

CHAIRMAN MILLER, DISTINGUISHED MEMBERS OF THE COMMITTEE, THANK YOU FOR PROVIDING THE OPPORTUNITY TO SPEAK TO YOU TODAY. I AM BILL ATKINS, DIRECTOR OF THE DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE (DASA). WE ARE THE SINGLE STATE AUTHORITY CHARGED WITH THE DEVELOPMENT AND IMPLEMENTATION OF ALL SUBSTANCE ABUSE TREATMENT AND PREVENTION PROGRAMS IN ILLINOIS.

NO ISSUE IS MORE IMPORTANT TO ME THAN THE PREVENTION OF DRUG AND ALCOHOL EXPOSURE TO UNBORN BABIES AND THUS SERVICES FOR THEIR PREGNANT MOTHERS AND OTHER CHILDBEARING AGE WOMEN. WE HAVE BEEN WORKING FOR MORE THAN TWO YEARS WITH GOVERNOR JAMES THOMPSON, ILLINOIS' LEGISLATORS AND OUR SISTER AGENCIES TO DEVELOP A COMPREHENSIVE CONTINUUM OF CARE FOR THESE WOMEN.

I WANT TO THANK THE SELECT COMMITTEE AND THE U.S. CONGRESS FOR ITS CONCERN ABOUT THIS PROBLEM AND ITS SUPPORT FOR THE DEVELOPMENT OF SPECIAL SERVICES THROUGH THE INCREASED FUNDING OF THE ALCOHOL, DRUG AND MENTAL HEALTH BLOCK GRANTS. WITHOUT THAT FUNDING AND GOVERNOR THOMPSON'S DRUG FREE ILLINOIS INITIATIVE, NONE OF WHAT I'M ABOUT TO DESCRIBE WOULD BE POSSIBLE.

I'M PROUD TOO, OF THE CONTINUUM OF CARE FOR CHILDBEARING AGE WOMAN, THE PREGNANT WOMEN, AND THE POST PARTUM WOMAN THAT WE ARE BUILDING IN ILLINOIS -- FROM PRIMARY PREVENTION THROUGH INTENSIVE RESIDENTIAL SERVICES.

ITS WORKING BECAUSE OF LEADERSHIP FROM THE TOP -- FROM THE GOVERNOR AND HIS HUMAN SERVICE AGENCY DIRECTORS. AND IT WORKS BECAUSE IT

RECRUITS WOMEN FROM ALL REFERRAL SOURCES, AND THROUGH OUR OWN AGGRESSIVE OUTREACH PROGRAMS.

WE KNOW IT WORKS BECAUSE WE HAVE OUTCOME EVALUATIONS THAT SAY IT WORKS.

TWO EARLY DEMONSTRATION PROJECTS FUNDED BY THE DEPARTMENT DESERVE SPECIAL MENTION. THEY HAVE PROVIDED THE MODEL AND DIRECTION FOR OUR CURRENT EFFORTS.

BOTH THREE-YEAR DEMONSTRATION PROJECTS WHICH CONSIDERED THE USE OF A COMBINATION OF TREATMENT AND P, 3ENTING SUPPORT IN A THERAPEUTIC ENVIRONMENT WHERE CHILDREN CAN STAY WITH THEIR MOTHERS.

ONE PROGRAM IN DOWNSTATE ILLINOIS -- WHICH CAN TAKE FOUR FAMILIES AT A TIME -- HAS A:

- 79% SUCCESS RATE
- OF THE 15 WOMEN WHO COMPLETED THE PROGRAM DURING THE EVALUATION, ALL ARE SOBER
- ALL HAVE JOBS OR ARE IN COLLEGE
- 23 OF THEIR 24 CHILDREN ARE PERMANENTLY IN MOTHERS' CUSTODY.

MANY OF THESE WOMEN HAD A LIFELONG HISTORY OF SUBSTANCE ABUSE FAILURES IN MALE DOMINATED TREATMENT SETTINGS.

THE OTHER SITE, DRAWING CLIENTS FROM CHICAGO AND ITS SUBURBS, HAS EXPERIENCED SIMILAR GRATIFYING RESULTS:

- 81% OF THOSE COMPLETING THE PROGRAM ARE DOING WELL, WHICH MEANS 63 WOMEN IN THREE YEARS HAVE STAYED SOBER, HAVE THEIR CHILDREN, AND ARE PRODUCTIVE CITIZENS. AS YOU MIGHT SUSPECT, MANY OF THESE WOMEN WERE PUBLIC AID RECIPIENTS.

THE TREATMENT PROGRAMS I DESCRIBE ARE NOT JUST BENEFICIAL FOR THE CLIENT. FOR EXAMPLE, OUR RESEARCH HAS SHOWN A DRAMATIC SAVINGS IN MEDICAL EXPENDITURES SIMPLY BY TREATING ALCOHOLICS AND DRUG ABUSERS.

WE FOUND SEVERAL YEARS AGO, IN A TWO-YEAR STUDY OF MEDICAID CLIENTS USING A MATCHED CONTROL GROUP, THAT:

- ILLINOIS SAVED HALF-A-MILLION DOLLARS IN MEDICAL COSTS FOR ONLY 176 CLIENTS.
- THE LOWER COSTS CONTINUED THROUGH THE LIFE OF THE STUDY.
- THE CLIENTS AND OTHER MEMBERS OF THE FAMILY USED FEWER MEDICAL SERVICES.
- THE COST OF TREATMENT THROUGH THE DASA SYSTEM WAS 1/3 THE COST OF SUCH CARE IN HOSPITALS, WHICH PROVIDED ADDITIONAL SAVINGS.

IN ILLINOIS TODAY, AS A RESULT OF THAT STUDY SUBSTANCE ABUSE SERVICES TO MEDICAID ELIGIBLE WOMAN ARE REIMBURSED TO COMMUNITY BASED AGENCIES - EXCEPT RESIDENTIAL SERVICES WHICH ARE NOT COLLECTING FEDERAL REIMBURSEMENT BECAUSE HCFA (HEALTH CARE FINANCING ADMINISTRATION) HAS DECLARED THEM IND'S (INSTITUTES FOR MENTAL DISEASES) WHICH ARE INELIGIBLE.

PAUSE:

LET ME BRIEFLY DESCRIBE ELEMENTS OF THE CONTINUUM OF SERVICES AVAILABLE TO PREGNANT AND POST PARTUM WOMEN IN ILLINOIS:

o PREVENTION

MUCH OF OUR PREVENTION EFFORT IS CENTERED AROUND A PROGRAM CALLED DRUG FREE FAMILIES WITH A FUTURE (OUR NAME FOR THE INTEGRATION OF THE INFANT MORTALITY NETWORK AND THE DRUG AND ALCOHOL TREATMENT & PREVENTION SYSTEM). WE HAVE PLACED MORE THAN TWENTY PREVENTION SPECIALISTS IN HIGH RISK COMMUNITIES THROUGHOUT ILLINOIS THIS YEAR. THE ROLE OF THESE SPECIALISTS IS TO ENGAGE SOCIAL AND HEALTH CARE WORKERS IN THE DRUG FREE FAMILIES WITH A FUTURE NETWORKS AND THEIR CLIENTS, CONCENTRATING ON TWO MAJOR PREVENTION STRATEGIES, NAMELY:

- INFORMATION AND PUBLIC EDUCATION ON ALCOHOL AND OTHER DRUG USE.

- SKILLS BUILDING AND COMMUNITY TRAINING.

DASA'S PREVENTION SPECIALISTS ARE ASSISTING FAMILIES WITH A FUTURE PROVIDERS IN DEVELOPING AND ENHANCING A DETAILED WORK PLAN. THE OVERALL FOCUS IS THAT ALCOHOL AND OTHER DRUGS ARE HARMFUL TO POTENTIAL PARENTS, THE FETUS AND GROWING CHILDREN. THIS PUBLIC EDUCATION PLAN IS MODELLED AFTER A PROJECT CALLED I-PASS, A WELL EVALUATED PERINATAL ADDICTIONS PUBLIC EDUCATION CAMPAIGN TARGETING PREGNANT WOMEN, UNDER 20-YEARS OLD, IN CHICAGO'S GRAND BOULEVARD AREA.

THESE DRUG FREE FAMILY SITES WILL BE SPECIALLY TARGETED WITH INDEPTH SKILLS BUILDING TRAINING. THERE ARE THREE SPECIFIC TYPES OF TRAINING:

- BASELINE TRAINING, WHICH PROVIDES A COMPLETE EXPERIENCIAL BASIS FOR UNDERSTANDING ALCOHOL AND OTHER DRUGS AND THEIR EFFECTS ON THE FAMILY.

- INDEPTH SKILLS BUILDING TRAINING ON PARENTING, USING "PREPARING FOR THE DRUG FREE YEARS", "EFFECTIVE BLACK PARENTING" AND "LOS NINOS" (DESIGNED FOR HISPANICS).

- INTERVENTION TRAINING OF ONE TO TWO DAYS TO LEARN ASSESSMENT AND REFERRAL PRACTICES.

TRAINING TAKES PLACE IN THE FOLLOWING SETTINGS:

- EACH SOCIAL SERVICE AGENCY FEEDING INTO THE SITES.

- CHURCHES LOCATED AT EACH SITE.
- EACH SCHOOL BUILDING IN THE TARGET AREAS.
- BUSINESSES LOCATED WITHIN EACH COMMUNITY AREA.

O INTERVENTION

THE DRUG FREE FAMILIES WITH A FUTURE PROGRAMS ALSO SERVE AS A REFERRAL SOURCE FOR THE NEXT STEP IN OUR CONTINUUM -- INTEGRATED FAMILY INTERVENTION TEAMS (IFIT). THE GOAL OF IFIT IS SIMPLE -- GET THE MOTHER SOBER AND/OR CLEAN, HELP HER TO DELIVER A HEALTHY DRUG FREE BABY AND KEEP HER FAMILY TOGETHER. THE CORE OF THE TEAMS ARE OUTREACH WORKERS AND CASE MANAGERS.

OUTREACH WORKERS FIND PREGNANT WOMEN AND NEW MOTHERS BY DOING GRASSROOTS OUTREACH. THEY VISIT JAILS, CLINICS, LAUNDROMATS, ETC. -- OR THEY GET REFERRALS FROM CHILD WELFARE AGENCIES, CHURCHES AND OTHER LOCAL INSTITUTIONS. THEY TRACK THE MOTHERS, AND PROVIDE TRANSPORTATION AND OTHER SUPPORT SERVICES AS NEEDED.

THE CASE MANAGERS PROVIDE THE LINK TO TRADITIONAL COMMUNITY PROVIDERS AND STATE AGENCY PERSONNEL --CHILD WELFARE, PUBLIC AID, PUBLIC HEALTH AND VOCATIONAL REHABILITATION. EACH AGENCY CONTRIBUTES STAFF TO THE IFIT TEAM TO HELP DEVELOP A PLAN FOR EACH YOUNG MOTHER. BESIDES SUBSTANCE ABUSE SERVICES, SHE MAY REQUIRE PRENATAL OR POST NATAL CARE, HOUSING, PARENTING SKILLS, JOB TRAINING ETC.

ELIGIBILITY CONTINUES TILL THE BABY IS ONE-YEAR OLD OR UNTIL THE MOTHER IS OFF DRUGS AND ALCOHOL. BABIES CAN ALSO BE REFERRED FOR DEVELOPMENTAL SERVICES IF NEEDED. FOLLOW-UP SERVICES HELP THE MOTHER STAY SOBER AND ENSURES THAT HER BABY RECEIVES WHATEVER SERVICES ARE NEEDED.

PROJECT SAFE

EARLIER I MENTIONED THE IMPORTANCE OF COOPERATIVE EFFORTS AMONG SISTER AGENCIES IN ILLINOIS WHO ARE CONCERNED ABOUT SUBSTANCE ABUSE AMONG WOMEN. ONE FINE EXAMPLE OF THIS SORT OF COOPERATION IS -- PROJECT SAFE, A PROGRAM JOINTLY DEVELOPED BY DASA AND THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS).

THIS AWARD WINNING/NATIONALLY RECOGNIZED PROGRAM COMBINES INTENSIVE OUTPATIENT ALCOHOLISM AND OTHER DRUG TREATMENT, WITH PARENT TRAINING FOR MOTHERS FOUND TO BE NEGLECTFUL BY DCFS. THESE TWO SERVICE ELEMENTS ARE SUPPORTED BY OUTREACH WORKERS WHO PROVIDE FREQUENT ASSISTANCE TO CLIENTS IN THEIR HOMES. WOMEN PARTICIPATE IN SPECIAL GROUPS WHICH FOCUS ON WOMEN'S ISSUES, AND THEY ATTEND SELF-HELP MEETINGS.

THE MODEL IS DESIGNED TO ACHIEVE SPECIFIC, MEASURABLE CHANGES IN THE MOTHERS' FUNCTIONING AND PARENTING BEHAVIOR.

THE EVALUATION OF THIS PROJECT SHOWS:

- SIGNIFICANT DECREASE IN ABUSE OF ALCOHOL AND OTHER DRUGS

- IMPROVED ATTITUDE TOWARD RECOVERY FROM ADDICTION
- ACHIEVED REDUCTIONS IN ANXIETY
- EXPERIENCED A FAMILY REUNIFICATION RATE OF 51% COMPARED TO EITHER 29.6% (CONTROL GROUP OF SUBSTANCE ABUSING WOMEN) OR 40% (CONTROL GROUP OF NON-USING WOMEN).
- 80% TREATMENT COMPLETION RATE COMPARED WITH 40% IN A TYPICAL SETTING.

WOMENS' TREATMENT PROJECTS

IN CONCLUDING MY REMARKS, I'D LIKE TO BRIEFLY TELL YOU ABOUT THREE SPECIAL PROJECTS UNDERWAY IN ILLINOIS WHICH WILL PROVIDE THE ENTIRE CONTINUUM OF CARE FOR SUBSTANCE ABUSING PREGNANT WOMEN WITH CHILDREN. THE CONTINUUM RANGES IN SCOPE FROM SOCIAL SETTING DETOX TO HALFWAY HOUSE AND OUTPATIENT PROGRAMS.

AS I MENTIONED EARLIER THERE ARE MANY PROBLEMS ASSOCIATED WITH THE TREATMENT OF THIS POPULATION, SOME CLINICAL AND SOME LOGISTICAL -- PRIMARILY BECAUSE OF "EXISTING CHILDREN" AND THE NEED TO PROVIDE CARE FOR THEM -- A PROBLEM WHICH OFTEN COMPLICATES OUR TASK, AND THAT TASK OF COURSE, IS TO ASSIST WITH THE PROTECTION OF THE FETUS, THE RECOVERY OF THE MOTHER, AND THE PRESERVATION OF THE FAMILY.

I. A NEW WOMEN'S TREATMENT CENTER IN CHICAGO IS BEING DEVELOPED IN A DEFAULTED WEST SIDE COMMUNITY HOSPITAL TO PROVIDE SERVICES FOR ADDICTED PREGNANT WOMEN WITH CHILDREN FROM THROUGHOUT ILLINOIS --OFFERING THE FULL CONTINUUM OF TREATMENT:

- o MEDICAL DETOXIFICATION.
- o RESIDENTIAL REHABILITATION WITH CAPACITY FOR CHILDREN TO STAY WITH THEIR MOTHERS DURING TREATMENT.
- o OUTPATIENT TREATMENT.
- o INTENSIVE OUTPATIENT TREATMENT.
- o HALFWAY HOUSE AND RECOVERY HOME SERVICES.
- o PREVENTION AND TRAINING SERVICES.
- o MEDICAL, SOCIAL, REMEDIAL EDUCATION AND VOCATIONAL SUPPORT SERVICES ON-SITE (THRU AN ARRAY OF INTERAGENCY AGREEMENTS AT THE STATE AND LOCAL LEVELS.)

II. THE CHICAGO CLERGY ASSOCIATION'S HAS IN THE PAST TWO MONTHS OPENED A MATERNAL ADDICTIONS CENTER TO PROVIDE TREATMENT RANGING FROM SOCIAL SETTING DETOX TO LONG TERM (DEPENDING ON LENGTH OF PREGNANCY) RESIDENTIAL REHAB TREATMENT FOR PREGNANT ABUSERS.

FOCUSING ON THE NEEDS OF THE WOMAN AND HER UNBORN CHILD. 19 BEDS FOR DETOX AND 22 FOR RESIDENTIAL REHABILITATION.

III. A JOINT PROJECT INVOLVING DASA AND DCFS AT COLUMBUS/MARYVILLE EMERGENCY RECEIVING SHELTER FOR ABUSED AND NEGLECTED CHILDREN IS TO BE EXPANDED BY 50-60 BEDS THIS SUMMER TO ACCOMMODATE POST-PARTUM WOMEN AND THEIR DRUG EXPOSED NEW-BORN BABIES. IN JANUARY OF THIS YEAR ILLINOIS IMPLEMENTED A LAW THAT PROVIDES FOR THE PROTECTION OF ANY NEWBORN WITH A CONTROLLED SUBSTANCE IN ITS BLOOD OR URINE.

THE FOCUS OF THIS PROGRAM IS ON FAMILY PRESERVATION AND REHABILITATION OF THE POSTPARTUM FEMALE. THE FACILITY, CURRENTLY UNDER RENOVATION IS BEING DESIGNED TO ACCOMMODATE MOTHER AND CHILDREN TOGETHER.

DASA'S PRIMARY ROLE IS TO CONCENTRATE ON MOTHER AS A PREGNANT SUBSTANCE ABUSE CLIENT, AND TO INTEGRATE PROGRAMS WITH DCFS'S REGARDING THE INFANT, SIBLINGS AND FAMILY IN GENERAL.

WITH INNOVATIVE AND COMPREHENSIVE PROGRAMS LIKE THESE, WE ARE FILLING GAPS WHICH EXIST WHEN IT COMES TO THE ALL-IMPORTANT TREATMENT NEEDS OF THIS VERY SPECIAL POPULATION.

AGAIN -- SIMPLY PUT -- THE ULTIMATE GOAL FOR ALL OF OUR PREVENTION, INTERVENTION AND TREATMENT EFFORTS, ESPECIALLY REGARDING ADDICTED PREGNANT WOMEN WITH CHILDREN, IS TO -- HELP HER DELIVER A HEALTHY BABY, GET THE MOTHER CLEAN --OFF ALCOHOL AND OTHER DRUGS, AND KEEP HER FAMILY TOGETHER WHEN EVER THAT IS POSSIBLE AND APPROPRIATE!

[EDITOR'S NOTE: "Confronting Tomorrow Today", A comprehensive State Plan for Drug/Alcohol Services FY 90 Update from Illinois Department of Alcoholism and Substance Abuse, is retained in committee files.

Drug Free Illinois (Action Report) is retained in committee files.

Understanding AIDS: A Multi-media Based Prevention Program, article entitled, is retained in committee files.

The Evaluation of the IPASS Project for FY 1988 (Final Report) is retained in committee files.

Families With A Future (FWF) Project, from Department of Alcoholism and Substance Abuse, is retained in committee files.

Project Safe, (fact sheet) is retained in committee files.

The Illinois Model, a State Collaborative Program for Alcohol and Other Drug Using Pregnant Women, is retained in committee files.]

STATEMENT OF BETH GLOVER REED, ASSOCIATE PROFESSOR OF SOCIAL WORK AND WOMEN'S STUDIES, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI

Dr. REED. I was asked to focus on the national picture and some data base behind that, and I want to stress several things.

Chairman MILLER. We need you to speak up or maybe pull one of those microphones a little closer to you.

Dr. REED. Is that better?

Chairman MILLER. Sure.

Dr. REED. I wanted to start out by saying that I am glad to hear you say that you are going to worry about the women even when they are not pregnant because as you noticed there in my first comment, I think if you look at the literature over the last 20 years, it focuses very heavily on women when they are pregnant and when they are perceived as being bad mothers.

While concern about the pregnancy is a major lever for getting women into treatment, if they are really going to recover and stay recovered, they have to start feeling better about themselves and have to start feeling that other people do not look down their noses at them every time they turn around. So the addictions field and policy issues have too often focused just on pregnancy.

Now I want to highlight some other things as well. These women face much more stigma than the typical addicted males do, which is a major barrier towards their seeking treatment. They internalize that stigma, they too feel that they are somehow worse than men who are addicted and worse than women who are not addicted. Many—a huge proportion in fact we think—of the women who develop severe addiction problems are incest survivors and some of what they are dealing with around the addiction really comes from other places and long-term recovery is going to require paying some attention to those issues as well.

Many of them have had no support in working through the effects of often repeated violence against them in their families, on the streets, and that needs to be attended to in treatment programs and in fact, usually is not. In fact, there is a fair amount of evidence that there may be more violence against women in many

typical treatment programs, although that is greatly improved in the past ten years.

I gave you another set of hand-outs that you might just want to look at. The data on the first page is what the research suggests that women who are addicted, who have alcohol and drug problems, look like compared to men. I should tell you that these patterns look just the way that women compared to men look when they are not addicted. There is nothing special about addicted women except that they have a range of health and social problem areas. And we have a service-delivery system that was really designed for men. And men with problems with chemical dependency live in a different world, in some ways, than women do, have different responsibilities, are perceived differently and that gets reflected in what they need in treatment programs.

Now a major failure of treatment programs that I think may be the worst failure is actually getting women into treatment. Some of it is related to the stigma that I was just talking about, some of it is related to our lack of understanding of how women feel about themselves and where they go for help when they know that they need it.

We have referral systems set up around chemical dependency programs that intersect in the areas in which men's problems bring them into contact with the systems around them. That includes employers for people who are still employed. It includes the criminal justice system, it includes family members because you often have family members—often a female partner or parents or sisters or brothers—really urging a man to get into treatment and clean up his act in one way, shape or form. In fact, the evidence and the research on women consistently shows that the people in their networks oppose their seeking treatment and subtly and not so subtly undermine their seeking treatment. There may be an exception while they are pregnant because everybody is worried about the baby. But there is just consistent research both with alcohol and with other drugs that women come into treatment in some ways against the wishes of their family. And that is a major problem.

You also have the situation where women have in fact sought help for one problem or another in a variety of different situations and different locations, in particular the health care system, the mental health system, with social services, and their addiction does not get picked up, or if it does, people do not know what to do about it. So you have, by the time a woman comes into treatment, often a whole laundry list of psychiatric diagnoses that may in fact be real psychiatric problems. I think it is more likely that it is post-traumatic stress around much of the violence that these women have experienced and a mis-diagnosis of alcohol and other drug problems that can look very much like various psychiatric conditions if they are being diagnosed by somebody who does not recognize the signs in women.

A second major problem, which is also related to this access problem, is the absence of women-sensitive services by and large. Now I did a training set of sessions for NIDA around the country a couple of years ago and took that occasion to ask people what was going on in their states in relationship to women and addiction. And I

would say compared to what I was hearing 15 years ago, there were a good many more all-women groups happening in treatment programs. That does seem to be a significant change. And almost every state reported at least one all-women specialized program but they also said that in some ways when you open up a women's program, then other programs stop trying as hard to deal with women within the context of what they are doing, which means we are not changing the treatment system in general, we are just adding on some special services for women.

My own bias is, and I think there is now substantial evidence that part of what we have to do is to transform the way we think about addiction and to get different kinds of services into all treatment programs, and I think they will also more effectively serve men, other kinds of men than we now reach, if we could do that.

Another problem that I wanted to highlight is the absence really of good research in this area. That list here on this first page, I put together in a form that didn't look very different from this 12 years ago, and what research there has been adds to this and reinforces it a little bit but I would argue that we knew much of what we know now about women who are addicted 15 years ago and just have not acted to do what needs to be done to change the service delivery system to more effectively reach women who have needs for substance abuse programming.

I wanted to reiterate several things that you have already heard. One is that I think you have to take the services out where the women are, which it sounds like what you are doing in Illinois. You have to help them get where they need to be, you have to help them understand that the alcohol and other drugs are being problematic for them. They may recognize that they have got all kinds of problems but may see the alcohol and drug use as a way of coping with the other problems rather than the problem itself.

I also think that the pregnancy is in fact a window of opportunity. Women clearly are more motivated to take care of themselves while they are pregnant, they are far more likely to come into contact with various kinds of human services and they often bond pretty heavily to the folks who take care of them while they are pregnant. And we can take advantage of that if we are able to follow up with them in a variety of ways.

One other thing that I wanted to point out in the other hand-out I gave you, which you can read. It is about the fifth page back where it says "Core Services for Women with Problems with Alcohol/Other Drugs". I do not know how clear this is. The underlined ones, you would have only if you were thinking about women. The ones in parentheses with asterisks are those that are far less likely to be found in a typical alcohol or drug program, and there is some evidence that all of them are necessary for women. And even in some of those areas where you do not see asterisks, like the vocational area or legal assistance, the kinds of vocational services and legal assistance that are available in most programs are not the kinds that are going to be most readily available for women, and a lot of people think that if they have responsibility for children, then that ought to be their vocation, although I think that is beginning to change.

I guess I will stop there and say that we have to find some way to build on the motivation while people are pregnant, but we also have to find some way to reach them when they are not pregnant and then to support them after the children are born, and to help them feel better about themselves as people because without some self-esteem and some sense of self-worth and some access to the opportunity structure, which means money, what is there besides staying addicted?

[Prepared statement of Beth Glover Reed, Ph.D., follows:]

Prepared Statement of Beth Glover Reed, Ph.D., University of Michigan, Ann Arbor, MI

I want to begin by thanking you for your concern about women (with children) who have problems with alcohol and other drugs. While the major reason for your concern is on the effects of mother's alcohol/other drug use on their born and unborn children, I urge you also to investigate and consider the needs of women as women, whether or not they have children. The addictions fields and social policy initiatives have too often focused primarily on the impact of mothers' use on children, often in ways that criticized and blamed the mothers.

Women with alcohol/other drug problems already face much more stigma than men do; the resulting shame and guilt are major barriers to their willingness to seek help, and often lead their families and partners to reject them and oppose their efforts to seek treatment and stop using. A large proportion of women who develop serious alcohol/other drug problems are survivors of incest, and have often also experienced rape and being battered as well. Few of them have had any support in working through the effects of these experiences, so their sense of self and self-esteem is practically non-existent. They often experience high levels of fear, anxiety, and depression as well. They may present a facade of toughness and defensiveness, which covers their fears and provides some protection, but which mostly confirms their view that others find them diepicable. Having hope for change, and a belief that they deserve and might attain a better life is too frightening to consider, given their history of disappointments and betrayals. [See handout for ways women differ from men.]

The message that women are important only when they are pregnant or a parent is a message about their own worth as human beings, as "throw-away" vessels, who are invisible and worthless except when pregnant. Addicted women have internalized this view of themselves, and a major goal of treatment has to be to change this view, so they see themselves and other women as worthwhile and useful people. To do this, they must learn to recognize their often strong coping and survival skills, and they need you and the larger society not to perpetuate or add to the stigma and shame that they feel.

In addition to this shame and societal rejection, I want to focus on three other factors that are major problems in working with women who have problems with alcohol and other drugs.

The first is the failure of treatment programs to develop effective outreach and referral systems that get women in need of treatment into treatment. In general, women with problems that arise from alcohol and other drugs are more likely than men with such problems to recognize that they are in difficulty and to blame themselves for their problemes. In fact, they are likely to feel guilty and ashamed about events in their own or their children's lives that they could not have prevented. They often seek help for their problems, in fact, but turn to health care, mental health, family service, and social welfare workers for assistance.

Most often, the possibility of alcohol/other drug use is not suspected or detected, and a woman is given additional medication for anxiety, depression and relationship problems. She is also likely to accumulate an impressive array of psychiatric diagnoses and be polyaddicted before anyone addresses her problems with alcohol/other drugs. The usual referral systems for substance abuse (criminal justice, employer, family, and health care) are less relevant or work less effectively for women. Despite this, many women find their way to substance abuse treatment, often more quickly after the beginning of drinking or use than men. Many others, however, never get to treatment, or have deteriorated much more than necessary before they do because of our service systems failure to recognize and support treatment for women. More access to treatment will require new referral systems and collaborative programming between systems that don't work together often now.

A second major problem is the relative absence of women-sensitive services. By women-sensitive, I mean services that are safe and don't further traumatize women, that address the range of problem areas that women are likely to have, and that provide services in ways that are compatible with a woman's interaction, thinking, and communication styles. I believe that this requires, at minimum, some women-only group experiences, but

for different types of women, it is likely to require much more. Interestingly enough, the few studies that examine any kind of treatment outcome, suggest that women who reach treatment actually achieve equal or better outcomes than men, despite most programs' lack of sensitivity to women's concerns and styles. Women use more units of service than men do, partly because they have a wider range of needs and more barriers to recovery than do comparable men, and partly because they request them. A much higher proportion of women than men do not reach treatment, however, and many leave in the early phases because the program is so incompatible with who they are and does not help them deal with the many difficulties that coming into treatment poses for them (see handout on barriers to treatment).

A third major problem in helping women to recover from problems with alcohol/other drugs is the paucity of well-designed research that focuses not just on women and how they differ from men, but also on what types of interventions work best with what types of women and problems. There has been little development of women-sensitive services and less evaluation of gender differences in needs, progress through treatment, and treatment outcome. NIDA and NIAAA funded some demonstration programs for women in the mid-70's, but there has been little systematic effort since then, either to develop specific programming or to describe it carefully, let alone to investigate its effectiveness in well-designed research studies.

What we do know about children, and their effects on their mothers and vice versa, suggests that women often enter treatment because of concern for their children. Just as worry about what will happen to their children, and a lack of options for children, are major barriers to treatment, attention to children's needs and to safe child-care options are likely to be major motivators for treatment. Addicted women may need parenting assistance while they are recovering, and many will need some time without child responsibilities in order to focus on themselves, but many want and need contact with their children on a regular basis. Studies have shown, that especially with support and training, women with alcohol/other drug problems can be and want to be effective parents. We must find some way to strengthen and build on this motivation.

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Characteristics of Women who have Problems with Alcohol and Other Drugs

(compared with men who have alcohol/drug problems)

Psychological
- -lower self-esteem
- -higher depression
- -higher anxiety

(learned helplessness)
- -believe that chemically-dependent women are worse than men with similar problems
- -life changes more disruptive
- -more interpersonally attuned
- -stereotypic gender role expectations

Employment/Education
- -great variability
- -lower income
- -less insurance
- -more dependent on social services
- -less work-related identity
- -poorer job history

Children
- -more often only or primary caregiver
- -concern and guilt about children are often major motivators for treatment

Roles
- -more multiple roles

Family/Relationships
- -more "disturbance" in family-of origin (evidence is mixed)
- -more isolated; smaller social support systems
- -partners more often are chemically dependent
- -more often victims of incest, sexual assault, battering
- -impact of ACOA may be greater

More likely to seek treatment
- -in smaller programs
- -if there are professional staff
- -if can deal with polydrugs
- -if program provides child and health services
- -if incest counseling, women's groups, pregnancy help

Sexuality
- -express more intimacy issues
- -may be more guilt about past sexual behavior
- -negative attitudes re: lesbians in treatment

Physical/Health
- -more medical problems
- -often they are more severe
- -physical problems get worse as they detox
- -more likely to seek medical/mental health assistance
- -more likely to be medicated

Crime/legal
- -less criminal involvement
- -less "serious" crime
- -less violent behavior
- -drive and are arrested less for DUIL/DWI
- -when arrested, receive more severe sentences
- -civil legal problems are important (e.g., custody, financial, housing)

Alcohol/Drug use
- -more polydrug
- -more licit drugs
- -perceive chemical use as means of coping with other issues/means of survival (pain, depression, relationships, responsibilities)
- -identify problematic use as dating from time of major life transition
- -shorter period of time from beginning of use to treatment

(Reed, 1988)

Sept. 1988

BARRIERS TO TREATMENT FOR WOMEN WITH PROBLEMS WITH ALCOHOL AND OTHER DRUGS

SOCIETAL ATTITUDES AND KNOWLEDGE

-Abuse of alcohol and use of illicit drugs is perceived more negatively in women than in men; thus women's problems are kept more hidden, they generate more shame, and once recognized, they are more punished.
-Women are more likely to use licit/prescribed drugs. Problems with these drugs are less recognized.
-Stereotypic protective attitudes about women lead to reduction of negative (especially legal) consequences.
-In general, even well trained persons have less knowledge about women and substance abuse. Women's substance abuse problems are not recognized, although they are often prescribed tranquilizers for depression
-Women activitists and staff of women's centers also have little knowledge of substance abuse. They rightly rejected earlier conceptions that women substance abusers are responsible for all the ways they are victimized, and in reaction to these attitudes, they resisted considering substance abuse as a factor at all.

CHARACTERISTICS OF WOMEN WITH PROBLEMS WITH ALCOHOL/OTHER DRUGS

-A woman does not understand that substance abuse is a problem and contributes to other problems; she perceives her use of substances as resulting from other problems; women are more likely to seek help than men, but seek help for what they perceive as their problem, not for substance abuse.
-Most women with substance abuse problems have high levels of depression and self blame and very low levels of self esteem. A woman is not likely to seek help if she feels un-worthy of help and is immobilized by depression.
-Multiple responsibilities, especially for children, and no childcare options, prevent her seeking help for herself
-Fewer people support/urge her to seek treatment; many significant others oppose and even sabotage treatment.
-Women suffer more negative consequences and disruptions from entering treatment--poorer health, loss of children and relationships, guilt, shame.
-Fewer economic resources and less likelihood of insurance
-Gender socialization predisposes women to attend to others' needs and be responsive to others' reactions, not to identify their own goals and seek actively to meet them
-Multiple problems overwhelm her and must also be addressed (some listed above). Others include histories of incest, rape, battering, health problems, and others

CHARACTERISTICS OF THE PREVENTION AND TREATMENT SYSTEM

-Casefinding and other referral systems for substance abuse are geared towards problems and incentives much more common in men (legal sentences, being fired, being left by spouse)
-Few referral arrangements are in place where women seek help: e.g., women's centers, social services, child-related settings, churches, health care settings, mental-health settings.
-Little knowledge and exchange has occurred between women's centers and substance abuse agencies because of differences in languages, assumptions, and priorities.
-In general, women's centers have not recognized or attended to substance-related problems.
-Substance abuse treatment services aren't compatible with women's needs or interaction styles; they may even deepen their depression and low self-esteem.
-Substance abuse programs often misperceive women's depression as denial or resistance to treatment.
-Sexual harassment and victimization occurs within substance abuse programs.
-Often there are no women role-models or enough women in influential positions within substance abuse programs to shape the "culture" of the program.
-Women are such a small proportion of the total number of clients that they experience "token" dynamics within substance abuse programs.
-Few resources are available for the longer term work that many women need to work on the multitude of issues they must work through to achieve some quality of life.
-Many staff members have not worked through their own issues with alcohol/other drug use by family members, with violence, sexuality/intimacy.

CHARACTERISTICS OF SUBSTANCE ABUSE PROGRAMS THAT DO ATTRACT WOMEN

-They are smaller (more intimate).
-They have a higher proportion of professional staff (more skilled in working with depression and low self esteem).
-They deal with alcohol and other drugs (most women use tranquilizers and other drugs as well as alcohol).
-They provide child care and child services, incest counseling, women's support groups, and pregnancy services.
-They conduct active outreach to women.

Reed, 1988

PRELIMINARY REED 12-88

WOMEN-ORIENTED SERVICES (minimum definition)

-Addresses women's needs
-Reduces barriers to recovery for women
-Delivered in a context that is
  -compatible with women's styles and orientation
  -safe and non-exploitive
-Takes into account women's roles, status and socialization
-Provides a variety of role models
(-Aggressive outreach)

Assessment of GENDER-SENSITIVE
SERVICES FOR ALCOHOL/DRUG PROBLEMS

- Number (proportion) of women on staff;
  Location/authority of women on staff

- Proportion of women among clients/patients/residents.
  (token or small proportion is destructive)

- Clear, well publicized and enforced (with both staff and clients)
  sexual harassment policies

- Types and range of services
  -See list of services needed
  -some all-women components
  -some attention to children
  -service orientation includes socio-cultural issues
    and consequences of devalued roles
  -education sessions include gender and skill, self-esteem focus

- Staff have knowledge of gender-related issues and charcteristics;
  these receive regular attention in staff development and in-
  service training activities

- Program has linkages to and activities with other groups and
  agencies concerned with women's issues

- There is attention to gender-related information at intake,
  during treatment planning, in record keeping, and in management
  information systems and evaluation.

- Attention is given to key policy questions concerning women--both
  in and outside the agency.

- Attention is given to culture/climate
  -Ideology (conscious and non-conscious)
  -Furnishings, decorations
  -Language, interaction style

- Staff attend to power relationships, among themselves, between
themselves and clients, and among clients

CORE SERVICES FOR WOMEN with PROBLEMS with ALCOHOL/OTHER DRUGS

Underlined = special for women

*( ) = less likely to be considered for men or included in a "typical" program

1. MEDICAL/HEALTH
   - -Diagnosis and treatment of problems
   - -Gynecological services
   - *Psychiatric assessment--coexisting disorders; agoraphobia, severe depression, eating disorders)
   - *(Health promotion--taking control of the body; assertiveness with health care providers; wellness education) (women's groups)
   - *(Prescription drug dependency)
   - *(Body image issues related to health) (women's groups)
   - -Pregnancy-related services: *(birth control education)

2. *(CHILD-RELATED)
   - *(Child-care; respite care; child placement & reunification; live-in)
   - *(Services to children--assessment, referral, education, treatment)
   - *(Parenting education/support) (women's groups)

3. FAMILY SERVICES
   - -Relationship counseling; marital and family therapy
   - -Work and education on family dynamics & addiction; Alanon.
   - -Co-dependency counseling

4. VOCATIONAL (some studies report that these are less often offered to women, although greatly needed) (women's groups)
   - -Job readiness *(self-esteem issues; identification of skills & strengths)
   - -Skill training
   - -Job seeking support and training *(self-esteem; sexual harassment issues)

5. *SKILL TRAINING TO DEVELOP SELF-ESTEEM AND COPING) (women's groups)
   - *(Assertiveness training)
   - *(Financial management)
   - *(Personal goal setting)
   - *(Stress and crisis management)
   - *(Communication & interpersonal skills; relationships with support systems)
   - *(Gender and socialization issues)
   - *(Other survival skills--transportation, etc.)

6. CHEMICAL DEPENDENCY EDUCATION
   - -Re: Physical, social, and family consequences of the disease/disorder--some content re: physical, psychological, and social consequences would differ for women.
   - -Preparation for self-help groups--12th step; Women for Sobriety

7. LEGAL ASSISTANCE
   - -Criminal issues--prostitution (others less likely)
   - -Drunk driving (less likely for women)
   - *(Civil matters--child custody, marital/domestic violence, financial, landlord & housing issues, harassment)

8. *(TRAUMA/POST TRAUMATIC STRESS DISORDER) (women's groups)
   - *(Incest, rape survivor issues)
   - *(Battered woman syndrome) (anti-violence work with partners)
   - *(12th stepping; sexual harassment prevention)

9. *(SEXUALITY AND INTIMACY) (women's groups)
   - *(Sexuality and drugs)
   - *(Counseling about fear of intimacy)
   - -Support groups--e.g., Daughters Anonymous
   - *("Loving too much" issues--ACOA, Being exclusively "other-oriented"--referral for longer term counseling and support groups)
   - -Sexual orientation issues

Reed 1985, adapted by Mondanaro 1987; revised Reed, 1990

TABLE 5

HOW TO REACH CHEMICALLY DEPENDENT WOMEN

1. Some women will self refer if they recognize a problem and know where to go to seek help (e.g. media campaigns, workshops).

2. Women can be identified by other signs of difficulty often associated with chemical dependency--patterns that may be related to etiology or those which may result from chemical dependency (e.g. medical problems, anxiety, stress, child, family or work difficulties, legal complications). Once identified, some women will acknowledge the problem and self-refer; others can be reached through the provision of other services and drug misuse identified after a relationship has begun.

3. Women in periods of life crisis or life transition may be particularly vulnerable to misuse of drugs and/or particularly receptive to seeking help (e.g. pregnancy, divorce, death or spouse or child, domestic violence, job loss). Crisis services can be trained to identify and provide services (or refer) for problems of chemical dependency.

4. Women can be identified by significant others and community "caretakers" with whom they interact.
   a. Educational programs might target friends, spouses, parents, children, other relatives.
   b. Those from whom women seek services in other areas of need or trouble can be trained to recognize signs of chemical dependency and make referrals.
      1. Medical personnel (private physicians, emergency rooms, etc.)
      2. Child-related services (runaway houses, child care centers, child protective workers, school staff, pediatricians)
      3. Legal & criminal justice personnel (civil & criminal)
      4. Social welfare and family agency workers
      5. Religious advisors
      6. Mental health workers, crisis centers, etc.
      7. Women's services & centers--shelters for battered women, continuing education programs, displaced-homemaker programs, assault crisis centers, etc.
   c. Employers, supervisors, co-workers.
   d. Caretakers who regularly interact with women in some domain of their lives and might recognize signs of trouble
      1. Many of those in (b) above
      2. Hair dressers, beauticians
      3. Pharmacists
      4. Library staff
   e. Current clients and those in the social networks with which chemically dependent women interact. With illicit drugs, these may include "street cultures", those involved in prostitution or selling drugs. For licit drugs, these may include social clubs, volunteer associations, church groups, recreational organizations, PTA's, LaLeche Leagues, etc.

5. Provide needed services for women and make them known.

Chairman MILLER. Thank you. Let me thank all of the members for your testimony.

Courtney, if I might ask you a couple of questions. Did you think about treatment during the early years of your addiction? Did you talk to other people about it or did you wonder about where you go for treatment or fear it or—what were your thoughts, if any?

Ms. X. I did seek treatment when I was 19.

Chairman MILLER. What happened?

Ms. X. It was co-ed and, you know, I just totally focused on this guy and I just—I did not take it serious either.

Chairman MILLER. You focused on a guy who was in treatment with you?

Ms. X. Yes.

Chairman MILLER. And what happened, you both continued to abuse drugs?

Ms. X. No, he left the program and I left and I started using again.

Chairman MILLER. Do you know now when you look back, why you might have left the program?

Ms. X. Yeah, because he left.

Chairman MILLER. He left.

Ms. X. Uh-huh.

Chairman MILLER. And you did not continue treatment and you relapsed back?

Ms. X. Yes.

Chairman MILLER. You also mentioned in your testimony—and this is something that we have heard before, and if I can just ask you and I appreciate it might be a little bit difficult for you, but you mentioned that from the time that your first child was adopted or in foster care and then taken away from you permanently, until your next pregnancy, was one of your heaviest times of drug usage. We have heard that from other women and they have explained that in part by just saying that they felt so bad, were so confused about the loss of that child that was taken from them, that they felt that was part of the contributing factors to their increased drug use and continued drug use later on. Can you explain that a little bit in terms of yourself, if that was true with you, if that was part of it, or was there something else going on?

Ms. X. I agree, to a point. You know, you have so many problems and any excuse will do just to pick up a drug I think, and then, you know, you are going through this with the loss of your child emotionally, and I started suppressing my feelings with drugs. I didn't want to feel that way any more, so I just kept using.

Chairman MILLER. And so you think it was the idea that you could get rid of your—of all of those other emotional feelings by the use of drugs to alter your state-of-mind, if you will, take the focus off of the pains or other feelings that you had.

Ms. X. Yes.

Chairman MILLER. Let me ask you if I might also, in terms of the skills that you are learning in the program. What do you think is sort of the strongest tool that you are learning—you are going to be graduating in May, what is it that you are going to take with

you from this program that you think is really going to give you the ability to continue to stay sober?

Ms. X. Accepting things, accepting life, living life on its own terms because that is one thing that was hard for me, just self-acceptance. I think—well I just would like to say this, even just coming here, I am using the tools that they have taught me, you know, coping with this setting, you know, being sober, you know, just for today.

Chairman MILLER. So rather than letting the fear of coming here or the excitement of coming here cause you to turn to drugs, dealing with this straight up, just saying this is something I am going to have to do.

Ms. X. It is similar, you know, yeah.

Chairman MILLER. Well there are a few politicians that have a glass of wine before a speech, we understand.

Ms. X. Yeah, you know. And then, you know, coming in here being honest, just being honest. That is all I did was lie.

Chairman MILLER. Do you plan to continue in the out-patient program?

Ms. X. Oh, yes, most definitely. It is a must for me.

Chairman MILLER. That is great. Thank you very much for your help.

Ms. X. Thank you.

Chairman MILLER. Dr. Reed, how typical or atypical are these responses?

Dr. REED. I would say pretty typical. It does not mean she does not have her own special issues, but I think the issue of feeling that—of wanting to suppress feelings that are just all bad is almost a common denominator.

Chairman MILLER. Dr. Poland.

Dr. POLAND. I agree.

Chairman MILLER. If this is the case, one of the things we are looking at is, as Mr. Atkins has pointed out and I think Ms. Walker pointed out, this movement away from other models and to try to customize programs to the needs of these women. Dr. Reed, you seem to suggest, and Beverly, you may be able to help us out here a little bit, that while an individual woman may be reluctant to go to treatment, you are suggesting that that reluctance is reinforced out in their community, whether it is their peers with them on the street or their family, that they really would prefer not to have these people engage in treatment. I guess in some places that is sort of like what they call people who enable other people, there are people who do not like to see other people get thin, so they keep offering them cherry pie. I am one of those, but—I eat the pie too——

I mean, this is a little bit different than what we are led to believe, that somehow this is an individual weakness and you just choose not to do this or you are a bad person and you decide you do not need treatment or you want to just continue on drugs. You say this is in fact formal reinforcement that is taking place within that community, however expansive that may be.

Dr. REED. And within the service system. I was just saying that it happens with physicians and with health care providers and——

Chairman MILLER. In what sense?

Dr. REED. In that people do not see the addictions, they do not ask the assessment questions. When they realize they have somebody with a problem, they do not know what to do about it.

Chairman MILLER. Let me ask you this, in terms of families and friends, is it more proactive than that, is it just ignoring the problem and hoping it will go away or is it actually saying "you are all right"?

Dr. REED. The studies are mixed from really active opposition to treatment and sabotage of her getting there, to much more subtle guilt-tripping about what is not going right at home or you are not worth saving—much more subtle. And it does not take very much when you have somebody who already feels totally ashamed and guilty about everything, for somebody to be read as being opposed to your getting better.

Chairman MILLER. Mr. Atkins, you were nodding your head when Dr. Reed was reading that segment of her testimony about people reinforcing this notion of not seeking treatment. Do you have some experience with that also?

Mr. ATKINS. Not being a woman, you understand, I do not profess to know all about that, but the family tends to be a system. What I was sensing I guess when she said that is that that is disruptive to that system, to have the woman leave and not provide the home care, not provide the meals and the laundry and whatever, and go into treatment. And so families tend to oftentimes discourage a woman going on, plus I think they tend to fear what kinds of changes will occur and how that will disrupt the family in the future.

Chairman MILLER. Marilyn, you interviewed the women directly. What do they——

Dr. POLAND. We found a variety of responses.

Chairman MILLER. Move that microphone over.

Dr. POLAND. We found a variety of responses. We did find the women that Dr. Reed was describing where the women were not encouraged to come and were actively discouraged. On the other hand, we also found a lot of women where the family would tolerate a drug or alcohol problem as long as they were not pregnant. But once they became pregnant, there was a sense of "it is your responsibility to do something for this fetus, for this baby", and so in many cases it was the family who would bring the woman in for prenatal care or for drug treatment or encourage her to come in.

We also found the same punitive behaviors in some of the health and social service institutions, of just not liking women who were using drugs. They are bad women and they should not be doing this. There is a punitive response. There were many women that we found that had this response until they came to a place like Eleonore Hutzel, where they found a family, where they found people who cared about them. And this began to really change around their feelings about themselves.

I might also mention that there is a whole chaotic lifestyle that very often goes with being heavily addicted to drugs. The women that we interviewed who were heavily into drugs moved often during pregnancy, one moved 25 times. Some of them are homeless. They are very often victims of physical abuse by the man that they

are living with. They are very often involved in environments where they are victims and there is a lot of fear of physical harm.

Women kept talking about running from shootings. One woman was shot in the stomach herself. Many of them live near crack houses in Detroit and these are very dangerous neighborhoods.

So all of these fears, these concerns, these pressures, together, create this lifestyle. And then within that, some families will encourage the women to go in for care and others will not.

Chairman MILLER. Well let me ask you and I will turn to my colleagues then. In terms of successful models, are we really talking, Beverly, about the need, or Marilyn, about the need to extract women from this environment essentially? I mean, it seems to me when we look at some of the programs that we fund—and I see this with some programs when we deal with young children, we take children out of an environment for an hour or two and then they are back in that environment for 22 hours, and we see no improvement, and you start to realize you cannot overcome the detrimental environment of 22 hours with two hours of child care.

Here, when you describe the environment in which many of these women are living, the instability, the chaos, in terms of really trying to ensure our best chance of success as a society in treating these women, are we really talking about a model that almost requires extracting them out of the community with residential treatment if the support mechanisms are not there within their families and communities?

Ms. CHISHOLM. We know through experience that if you do not disrupt the normal living patterns, especially of the cocaine addicted, that your ability to impact on successful treatment is going to be very limited. What we have done very effectively in the Eleonore Hutzel model is to bring women from their—we have disrupted that pattern, we have brought them from where they now exist into a program that takes a lot of time out of the day, a minimum of five hours out of their day, because the usage pattern itself is so cyclic, if you break that pattern, it gives that woman an opportunity to relax and to sit back and to have a mindset.

When you are actively involved in the pattern, it is very difficult for you to stop and think that, you know, maybe this is not conducive to a normal lifestyle.

I need to say something about the family too. We are talking about the family systems as if they are functional. We are basically talking about dysfunctional families. We are talking about people within the family structure itself that also need treatment, we are talking about codependent individuals who also need to see that there is a problem within the system, but because of the shame/guilt factor and the stigma that is attached, family members often times try to self-cure rather than to submit that person to treatment, because the family has to admit there is a problem in the system and no one really wants to admit that, and women stay out longer.

You heard Courtney speak to the problems in being in co-ed programs. It affords that woman an opportunity to focus, and that is what Courtney said happened to her. Instead of focusing on my treatment, I got involved in a relationship which helped me to focus, and we are looking for things to be focused from treatment.

So it is important that we remove as many barriers as possible, and that is what a holistic model attempts to do.

Dr. REED. Can I just add one thing? I agree with all of this, I also think that it is probably unrealistic to think about very intensive all-women programs all over every state in the country. Somehow or other we have to figure out how to get what is working in some of these intensive all-women programs into programs in every little town all around the country, because I do not think it is going to be cost-effective to do it otherwise.

Chairman MILLER. I guess my concern is that we look at some models for drug treatment that are based on, if you will, white, middle class people from a stable environment getting 30 days of treatment in the best private hospital in the city and somehow they are cured.

Ms. CHISHOLM. Fourteen days.

Chairman MILLER. Fourteen days, whatever the insurance company will dictate and when the payment runs out, so does your treatment.

But the point being that that model has really little or no relevancy to these communities because of the environmental instability and chaos within the family and the community. When we talk about how we use Medicaid money or how we join these different pools of money together between state and federal governments, we have got to look at the fact that almost none of them provide for after-care, right?

Ms. CHISHOLM. Right.

Chairman MILLER. So you think how you front-load the cost so that you can then extend to Courtney after-care. I look at successful models in California for young people and they are talking about 125 contacts during the next year. Well I do not know anybody that is talking about funding those, but they fund it because they cheat on the front end and everybody sort of nods and says okay, because you are successful, we will let you use some federal monies in that fashion or we will not cite you, I do not know what they do. But in any case, we are talking about more intensive programs, given the intensity of the addiction, and then the non-supportive nature of the environment.

Ms. CHISHOLM. I think you absolutely have to look at that. If we are—we are presently looking at, and I know you hear often the cry for additional funds, but it is impossible with stagnated funds, to be progressive simultaneously. There is just not a possibility of doing that. I think everybody would love to—we are talking about program enhancement a lot more than we are expansion. If you look at—we feel like we have a pretty good model that is stable, that is effective, that works. What we need now is an ability to expand what we already offer and that is the model that we are talking about making a national package, that is the model that needs to be out there. You have to move your treatment criteria with the primary substance abuse pattern.

Cocaine, this crack cocaine population does not fit into an opiate male model. It will not work, it has not worked. For programs that attempt to continue to try and force it to work, they are not reporting to you the success rates because they have not been progressive, and it is because of limited funds and it is because we are

seeing in epidemic proportions nationally—we are not talking about a city just like Detroit, we are talking about throughout this nation. We are in an epidemic.

We are talking about a war on drugs and very few soldiers. There needs to be an army out there and it takes money to keep a military going.

Chairman MILLER. On that subject, Congressman Levin.

Mr. LEVIN. Mr. Atkins, you wanted to comment on that? I was going to ask you a follow-up question and maybe you are anticipating. Go ahead.

Mr. ATKINS. Go ahead.

Mr. LEVIN. I was going to ask and then you comment, so what is the gist of the problem—it may be dangerous to ask that about a problem of this size. Is it that we do not know enough, is it too complicated, is it part of a larger problem, is it isolated? And you know, frankly that question occurred to me as I was listening to your testimony because you were describing a program in the State of Illinois which has what, 11 million, 12 million?

Mr. ATKINS. Yes.

Mr. LEVIN. And you were talking about 19 beds and 22—and I wondered, in a universe, in a state the size of Illinois or Michigan, what does that all mean? We do not have the models yet, it is a new problem? What is going on here?

Mr. ATKINS. I think we are developing the models, Congressman. In Illinois, we estimate a need for 53,200 publicly funded admissions to our treatment system. That is working down the population on an incidence prevalence level and then taking a portion of that population that has to be publicly supported, that cannot access the treatment system and pay for it with private health insurance.

Mr. LEVIN. There are 53,200 who need public support for their addiction problem—let us put it in simple clear terms, all right?

Mr. ATKINS. Right.

Mr. LEVIN. That is what that figure meant?

Mr. ATKINS. Women.

Mr. LEVIN. Oh, women.

Mr. ATKINS. For their addiction problems.

Mr. LEVIN. And you are going to tell us about how many——

Mr. ATKINS. That is admissions to the system, that is out-patient, that is detox, that is——

Mr. LEVIN. Okay.

Mr. ATKINS. At the moment, we are providing 18,000 each year. So as I described to you a fairly comprehensive program, we are in the beginning of bringing that system up and, as Dr. Reed said, we have known many of the things we have known for 15 years, but we have not until now had the resources to develop the special programs.

As a state director, I concur with Dr. Reed that you cannot have special residential programs for women in every small town in rural Illinois, but I do think that you can have special residential programs in areas that can be accessed by those small towns, and put the out-patient programs and the detox programs that can receive these women into the system and refer them on for special residential, and I believe Congressman Miller mentioned the need

for after-care and in my opinion that is critical. If you do not have a strong after-care system, both an AA type system as well as ongoing professional support, vocational, educational, human service kinds of things, you might as well stop spending your dollars on the residential because you just turn them over in 28 or 14 day programs, whatever that is.

So next year we are focusing on the development of halfway houses and recovery homes where women that come into our residential programs can go out. And I am working at the moment with the Chicago Housing Authority to do some of that within their structure.

I would like to, if I may, Congressman, comment on the Medicaid issue because Illinois was part of the HCFA demonstration several years ago and as a result of that put in place a Medicaid system that does pay for these services, and when we refer back to the need to integrate health care, OB–GYN services with substance abuse services so that we can identify women as early as possible who need help and bring them into an appropriate treatment program, Medicaid is a way of helping to do that.

But what we most need I think is long-term stable funding for the community-based substance abuse treatment system, and Medicaid can help us do that with the very high-risk population that it supports. The problem we have in Illinois is the issue that I referred to when I was speaking, the Institute for Mental Disease issue, where any facility 16 beds or over is classified as an Institute for Mental Disease and it is not, therefore, reimbursable. The concern that that provides is that 16 beds is not a cost-effective size of a program, you cannot staff it up 24 hours a day and put the kind of professional services you need in for only 16 women or only 16 anybodys, children, anything.

I think it is kind of an arbitrary number that really needs to be looked at from federal policy because what it does is force us to deliver services in hospital-based programs that are Medicaid reimbursed at three to four times the rate. So for $100 a day, I can do it in a community based program, equivalent or better care, and for four or five hundred dollars a day you can do it in a hospital-based program. And that's the dichotomy that we have going right now, and Medicaid is supporting that process.

Dr. REED. Can I just add one other thing? We have been talking about the follow up to primary treatment. I think with women, we have to talk about a big piece in front. In Michigan, people are calling that pre-treatment because we do not have any better language for it and we can maybe sometimes get funded for pre-treatment or outreach. But when you are talking about the level of self-esteem problems that most women who become addicted have, they need consistent outreach and a lot of bolstering of their feelings that they are worth somebody paying attention to before you can get them to come into treatment. And in Michigan, we are seeing this in at least three ways that I am familiar with. One is in battered women shelters where it turns out the substance abuse people do not know very much about how to work with those women because they are not seeing them yet. They are several years before they actually show up in treatment programs. I think the "Families First" programs in Michigan decided deliberately not to exclude

people who were addicted from that family preservation work, which has been the case more in other states, and they are suddenly faced with what do we do with all these folks, some of whom need treatment, some of whom may not need treatment, but they need some kind of sophisticated work around developing substance abuse programs. And we are seeing it in the homeless shelters where there is clearly a very high level of use and people who have never been in a treatment program or have been in and out like a revolving door.

There was also an innovative study some years ago in emergency rooms where they picked up women who were coming into emergency rooms either with child problems or adult problems, never been in a treatment program at all but with very severe addictions. Most of our treatment programs have not the foggiest idea what to do with those folks.

Mr. ATKINS. Before we leave the Medicaid issue, I think the study that has been done in Illinois has been replicated in some other parts of the country and that is the cost offset of treating people with alcohol and substance abuse problems and the net savings almost immediate to the health care system for members of the family as well as the substance abuser.

Chairman MILLER. We cannot get any credit for that in the budgetary process.

Mr. ATKINS. Well you would because the public aid dollar automatically goes down. Our research can show you——

Chairman MILLER. I mean in Congress when we try to factor in that kind of increase for treatment, you get no offset for savings that you may realize. It is an in-house problem that we have that prevents this kind of approach.

Anything else?

Mr. LEVIN. No.

Chairman MILLER. Congressman Holloway?

Mr. HOLLOWAY. Courtney, let me start out by saying we appreciate you coming forward and giving your testimony. We hope your life is totally straightened out and you are very productive as a citizen in the future.

I just want to ask you one question. When you had your first two children, of course you were an active addict, and you refused help. Do you feel that an individual such as you—and I think you pretty well testified to this—is better off allowing your child to go up for adoption? If you do not feel this way, do you feel that there should be pressure from the public to allow that child to be put up for adoption?

Ms. CHISHOLM. Courtney is asking that you repeat the question.

Mr. HOLLOWAY. Well what I am asking is when a woman—and I am speaking of you in particular since you are an excellent example just having testified—is an active addict and chooses to continue using drugs and refuses help, in these cases, do you think adoption should be encouraged? In other words, do you think in the cases of your first two children, you should have been encouraged, if you were not willing, to give them up for adoption?

Ms. X. Yes.

Mr. HOLLOWAY. You feel your children are better off today, your first two children, than they would have been trying to follow you through those years of your life.

Ms. X. Yes, I do.

Mr. HOLLOWAY. That is the only question I really have. However, I would like to say I am very thankful for the help that you are getting and the fact that you have a third child and you are hopefully able to raise that child in a good family. Thank goodness for that. We appreciate you coming forward and being willing to testify to us.

I guess the most outstanding or unusual testimony that I have heard comes from Ms. Poland. In your testimony you stated that among the four groups of women you studied, education or the amount of health insurance did not contribute to the amount of prenatal care or birth weight. I wish you would expound upon that, I find that totally flabbergasting, to say the least.

Dr. POLAND. We were surprised also, but we found that there were no differences in education. The average years of education I believe across the four groups was something like 11 years, four months of education. In other words, just under high school, but there were no differences among the four groups. And the same for amount of insurance the women had or whether they had any insurance at all, the women were no different in this.

Now we do find significant differences when you take a look at access to prenatal care only, in that women who have less insurance get less care. In many cases, however, when you look further at this, it is not not having insurance, it is not seeking it. But we did not find it when we took a look across the four groups.

Mr. HOLLOWAY. That is very, very unusual from what we hear in Washington today.

Mr. Atkins, of course I want to go back just a second to Medicaid. I want to know how you all cross the line without—how were you all able to use Medicaid, the reimbursements from it without us as big federal boys coming in and doing it for you.

Mr. ATKINS. As I said, Congressman, Illinois was one of I believe six states in a HCFA study that was done over five years ago before I came to the Department. That study I believe is still around and may be useful to look at. From there, we approached the Department of Public Aid in Illinois to rewrite the state plan and to include that. The Department of Public Aid in Illinois does reimburse for residential services, but they do not collect the reimbursement from the federal government, so they do not bill it out to the feds. That is a sore point between myself and Director Pester, but one we would like to see a solution to.

Mr. HOLLOWAY. On page 6 of your testimony you said the public education plan you model your program after—could you give us a little more information on that, and basically compare it with the basic cost of your education.

Mr. ATKINS. The I-PASS plan?

Mr. HOLLOWAY. Yes.

Mr. ATKINS. I would be glad to. Basically what we did was take an area and saturate it with public information about smoking, alcohol and drugs and the effect on young children, and we concentrated on, as I said, women 20 years of age and younger. They did a

controlled study and I would be glad to see that the Committee gets a copy of that controlled study. What they found basically was that it does have an impact and that both intensity and duration of information delivered in an appropriate way can help change people's behaviors and we saw a reduction in the infant mortality rates in that particular neighborhood. We are now taking that and replicating it into the high-risk infant mortality communities in Illinois to support what we believe needs to be a comprehensive program, ranging from prevention and education all the way through to the after-care and continuing support systems for this population as well as all other populations that need specialized help.

Mr. HOLLOWAY. How much did this cost you?

Mr. ATKINS. I believe we had about $200,000 into that study and that includes the research side of it.

Mr. HOLLOWAY. One other question that I would like to ask you is that maybe the only solution on a nationwide basis, or the best solution we have, is working with the churches to try to educate. How did you work your program so that you were able to work with the churches and dioceses of your state?

Mr. ATKINS. We have a very strong relationship with both Catholic and Lutheran and Baptist organizations and have worked with the Jewish community as well. We find it to be a very appropriate system to deliver prevention and education and early intervention services, so that ministers who come in contact with people day in and day out that have substance abuse problems or parents who have children who are abusing, have access to refer these individuals into the treatment system and we can outreach to the families and to the homes that are identified this way.

We approached them, they were more than interested in working with us. They, like many other community organizations, physicians, teachers and other people that come in contact with people all the time, see an awful lot of this in their lives and as a helping group, they are anxious to find places to send them to, so they were very receptive.

Mr. HOLLOWAY. I guess to me that would be very much like sending a worker in from the suburbs of Detroit into the inner cities to solve the problems versus a church group that knows the problems and knows the families, being able to go in and help. I guess we all believe in a separation of church and state, but I think we are going to have to use the churches in our country to be able to solve some of these problems, or else I do not see a viable solution to them. Especially, in the rural areas; parts of this country that we cannot reach through a hospital.

Thank you very much, all of you, for your testimony.

Chairman MILLER. Congressman Durbin.

Mr. DURBIN. Thank you. I only have two areas and I think we covered most of the major points here. But it seems that when we are talking about addicted mothers, we are talking about a woman who has made two decisions. The first decision related to addiction, the second decision, except in those cases where the pregnancy was the result of a forced crime, incest, rape or something, there is a decision on the part of the woman as it relates to becoming a mother.

I am wondering if you could tell me what you found, perhaps Ms. Chisholm, in your experience at the center there, what is the attitude of the women that you work with about birth control, about abortion, about alternatives to avoiding or ending pregnancy?

Ms. CHISHOLM. I first have to beg the issue, the women making a decision to become parents, to become impregnated, to become even aware that the pregnancy exists. We could have a woman actively enter our doors in her seventh, eighth month of pregnancy and still deny the fact that she is about to give birth. What we have to work very stringently toward is breaking through the denials, helping the woman understand herself, helping her understand the parenting issues.

The substance abuse portion of this woman's life becomes the precipitator of everything else that happens with her. That is the number one mandate. It is to mask all the other things that you mentioned, it is to mask the incest, it is to mask the rapes, it is to mask everything else that is happening in that person's life that they cannot or choose not to deal with at that particular instant. That is why they use drugs, it is to alleviate the stressors, it is to forget them, it is to not to have to deal with them.

So we do not find people who are consciously aware, who are coming through our doors saying I have been victimized and that is why I am a substance abuser.

Mr. DURBIN. If I could go back though, maybe I was not clear.

Ms. CHISHOLM. Sure.

Mr. DURBIN. If it is not a decision as to pregnancy, there has to be some—should be some sort of decision as to birth control. Are you suggesting that this type of addictive mind is not prepared to even deal with that question on birth control?

Ms. CHISHOLM. I am saying you are exactly right. In the addiction, that is not even a part of the decision-making process. It is something that the women will learn as a part of treatment, but we first have to get them there, that first step has to be taken.

Mr. DURBIN. And as they come out of your treatment, is that part of their education?

Ms. CHISHOLM. It very definitely is a part of our treatment, to introduce to them self-care, self-esteem, self-help methods. And that is understanding one's self. To understand yourself, you need to understand your body, you need to understand where you come from, all the issues of self-esteem.

Mr. DURBIN. I met one of the mothers at your center when we visited earlier this morning and it was an interesting conversation. She talked about what life was like—I believe she referred to an area Highland, that——

Ms. CHISHOLM. Highland Park.

Mr. DURBIN [continuing]. She lived in, and the availability of crack and how the street price of crack has gone down from $20.00 to $8.00 and how easy and available it is. And she said, "Well the weekend is over," in kind of a—she gave me the impression it was kind of an anxious time, Monday morning, to see how many of the mothers had been able to live through a weekend and not use a substance, crack or whatever it happens to be. And I can understand that. That is a period of 48 hours maybe since you have seen that mother.

Ms. CHISHOLM. Uh-huh.

Mr. DURBIN. You talk about the whole nature of your process is to disrupt the life pattern, to bring a mother and her child out of the terrible environment, bring them into the center for a period of months, maybe even longer, to try to get them to take a brand new look at their life, but it all comes to an end. In Courtney's case, it will be in May, and then she is going to have to look to another life after that.

Ms. CHISHOLM. That is right.

Mr. DURBIN. What kind of preparation, what kind of training or what kind of experience is offered to this woman so that now since she does not have to report in on a daily basis, she can say "I can do this myself," what can you add to that?

Ms. CHISHOLM. There is a full introduction of—there is a knowledge base of coping skills; how to say no, and what is more important, why one should say no. We have heard of the "Just say no" campaigns, and we know why they do not effectively work in a city such as this. It is like take that nice addiction, any addiction that you may think of, take the folks who may say to you, "Before I have the first cup of coffee in the morning, I am not a human being, do not even talk to me." Just say no to that cup of coffee.

Sometimes we have to look at the fact or the person who associates every good meal with a cigarette—do not smoke. How easy is that? I think when we think of our own nice addictions—and I was horrified when I read a book, and I love chocolate, that was called "From chocolate to heroin". You have to understand that there is an addictive personality, addictive pattern that has to be educated. We do it through education. We teach them why. And we do not criticize the history, what we do is say there is a history, you cannot change that, but you have every reason to and you should impact on your future. You do not have to stay in this, get out.

Mr. DURBIN. Courtney, let me ask you about your future, where are you headed after graduation, what is your future?

Ms. X. What is my future? Well I have set a short-term goal for myself and a long-term goal for myself. I plan on going back to school and I would like to be a nurse. Well that is my long-term goal, but my short-term goal is to take a few courses in substance abuse and, you know, maintain sobriety and after, you know, my year of being sober, help someone that needs to be helped and wants to be helped, because it was so freely given to me.

Mr. DURBIN. Good for you. I think the fact that you made it through this hearing today is an indication you are off on the right start. Good luck.

Ms. X. Thanks.

Chairman MILLER. It certainly indicates you have a lot of patience. [Laughter.]

Thank you very much for your testimony and for your help. And Beverly, if I might, let me just thank you very much for helping us to arrange this hearing and I think that Detroit ought to be very proud of this hospital and of your treatment program.

Ms. CHISHOLM. Thank you very much.

Chairman MILLER. It is what brought us here and I think we have learned a great deal.

Ms. CHISHOLM. There is a very capable staff out there.

Chairman MILLER. I am sure of that.

Ms. CHISHOLM. Thank you.

Chairman MILLER. None of us would be sitting at this table without staff. Let me also say that I think this has been very helpful in terms of our trying to get a more complete portrait of these women because I think, just as sure as the sun comes up, we are going to have another drug initiative before the election. It seems to coincide with election years. I think for us to really try to do our best in terms of national policy, we need to know more about these women. Unfortunately I think today we spend most of the time sort of condemning the outcome and that has not been terribly helpful in terms of mitigation. Thank you very much, all of you for your help.

You are excused.

It is the intent of the committee to continue straight on through and with that, we will hear from our second panel now if they would come forward. Randall Todd, who is the Director of Health Promotion and Disease Prevention for Kent County Health Department, Grand Rapids; Joyce Scott, who is the Executive Director of West Side Futures; Maisha Kenyatta, who is the Director of Hope, Unity and Growth from Detroit; Lisa Potti, who is the Program Coordinator, Mother and Infant Substance Addiction Network, Detroit Health Department; Charlene Johnson, who is the President and Chief Operating Officer of REACH, Inc., who will be accompanied by the Reverend Lee A. Earl, who is the pastor of the Twelfth Street Baptist Church and Chairman of the Board of REACH here in Detroit.

Somehow we are going to have to fit you all in here. Maybe what we can do is take you in the order—Mr. Todd, Scott and Ms. Kenyatta. We may have to juggle chairs here a little bit, but we are anxious to hear your testimony.

Your prepared statements will be placed in the record in their entirety. The extent to which you can summarize would be appreciated so that we will have time for questions, and also the extent to which you feel the need to comment on something that you heard here before, please feel free to do so. That is helpful to the Committee.

Let me also say while we are changing panels here, for individuals in the audience that believe they have something they want to contribute to the subject matter and to these hearings, the record of this hearing will be held open for a period of two weeks, so if you have something that you want to submit, you are more than welcome to send that to the Select Committee on Children, Youth, and Families, House of Representatives, Washington, D.C. 20515, and we would welcome that as part of the formal record of this hearing.

With that, Mr. Todd, we are going to start with you. Any other conversations—if we could ask if you would have your conversations outside, this room is very conducive to conversations in the back coming right down here, so we will eavesdrop on your conversations if you do not leave the room. Go ahead, Mr. Todd.

STATEMENT OF RANDALL L. TODD, DIRECTOR, HEALTH PROMOTION AND DISEASE PREVENTION, KENT COUNTY HEALTH DEPARTMENT, GRAND RAPIDS, MI

Mr. TODD. Thank you, Mr. Chairman and members of the Committee for giving me the opportunity to speak today.

You have been hearing a lot in previous testimony about illegal substance abuse and I would like to ask you to shift gears a little bit and consider abuse of a substance by pregnant women which is completely legal in this country. I am speaking of tobacco use by pregnant women.

We know that tobacco used during pregnancy is an important modifiable risk factor with low birth weight and it is also correlated with increased risk of early fetal loss. It is projected that if all pregnant women stopped smoking, the number of fetal and infant deaths would be reduced by ten percent. It has also been estimated that an average cost of neonatal care is $189 higher for infants born to smokers. Those are 1983 dollars. Smoking in pregnancy has also been linked to post-natal complications and smoking doubles the risk of sudden infant death syndrome.

Now some attention certainly needs to be paid to reducing this type of risk. And traditional smoking cessation clinics usually involve multiple educational sessions offered over a period of weeks. These impose some transportation and time constraints on the pregnant population. In recent years, we have seen a trend toward some self-help programs for smoking cessation. These techniques generally rely on a lot of written material and rely on the ability of the individual to read that material and their motivation to read that material.

I would like to describe briefly to you a pilot project that we tried in Kent County from August of 1985 until August of 1986. We proceeded with this project through funding from the State Health Department, which was then called the Health Education and Lifestyle Project, and this was one small component of that project. Our initial intent was to simply provide women who enter our special supplemental food program for women, infants and children with some additional information that they normally do not get in receiving that care, about smoking in the hope that they would be able to quit.

We were fortunate to have a doctoral candidate who now works for the General Accounting Office, his name is Jeff Meyer, who needed a dissertation project at the time, and so we developed a quasi-experimental design where we were able to bring the women in, we did a pretest interview with them, found that 42 percent of the women entering our clinic, the pregnant women entering our clinic, were smokers. That compares with other estimates of smoking among women of child-bearing age of around 32 percent nationwide. Some other estimates from other WIC programs in other states have found similar percentages of smoking among WIC moms, in the neighborhood of 40 to 45 percent, depending on where you ask.

It is also a general feeling that a very small percentage of WIC moms actually stop smoking during their pregnancy. So we felt this was an important group to intervene with.

After identifying the smokers as they came into our clinic, we randomly assigned them to one of three different groups. We had a usual care group which got the standard information that it is not a good idea to smoke during your pregnancy, we then had a special information group that received some additional counseling, about ten minutes worth, from a health educator and then we had a multiple component group that received the same counseling information but had an additional ten minutes of behavior change methodology shared with them. They were also given a self-help manual that they could take with them. Primary behavior change techniques were self-monitoring and self-contracting.

We followed these women up at their first visit to the WIC clinic postpartum and reassessed their smoking status, asking them about their smoking at the time of delivery and about their smoking postpartum. We did find that we had a slight reduction in all three groups, we got an 11 percent quit rate in the multiple component group that had the 20 minute intervention with the information and the behavior change techniques.

We feel that this is important. Ten percent may not seem like a whole lot, but if you look at smoking cessation programs nationwide, 20 to 30 percent is what you would expect to see in a clinic that sees patients over a period of seven to eight weeks for a couple of hours at each session. Here we had a 20 minute intervention, which was very brief, did not interfere very much with the clinic flow and yet achieved an 11 percent quit rate. This, coupled with the fact that we have a high rate of smokers in the WIC clinic, that we do not have any problem with recruiting women to the WIC clinic—in fact, most WIC clinics run waiting lists of people trying to get in. We see in our clinic in Kent County in the vicinity of 4,000 pregnant women coming through our doors each year, 42 percent of them being exposed to this intervention and 10 to 11 percent of those quitting we feel is quite significant and can result in some cost savings.

Unfortunately, with the cessation of our grant activities, we also had to cease the intervention. We are presently pursuing some other sources of money so that we can reinstate that. I think it would be ideal if it were implemented in WIC clinics as a basic part of the WIC service, much in the same way that nutrition education is a basic part of the WIC service. We frequently are asked to increase our caseload, there is usually money attached to that request but often that money is barely adequate to staff so that we can provide the basic required services.

This technique has been tried elsewhere in the state with somewhat less success and I think the differences are instructive. In other places where it has been tried with the WIC population, the clients have been asked to return for a separate session. That did not work as well, it seems to be important to getting the participation. We had 81 percent of the smoking moms agree to participate in our study. We do not feel we would have gotten that kind of participation if we had made them come back to a separate session, we got them when they were in the clinic.

The other thing that I think is important is that our interventionist was an integral part of the WIC staff. We had her work on the staff, with that staff for two months before we even began to do

interventions, so she was very much a part of that team. And in other places where this has been tried, the WIC staff may in some ways, knowingly or otherwise, sabotage the efforts of the intervention team for smoking cessation.

So we felt that this is something that should be considered when you are talking about substance abuse and the effects on prenatal care. Even though this is a legal substance, we feel that it should be addressed because of its devastating effects on the moms.

Thank you.

Chairman MILLER. Thank you.

Ms. Scott.

[Prepared statement of Randall Todd follows:]

Prepared Statement of Randall L. Todd, D.H.S.C., M.P.H. Director, Health Promotion and Disease Prevention, Kent County Health Department, Grand Rapids, MI

Mr. Chairman and members of the committee, thank you for giving me the opportunity to speak on behalf of thousands of infants who are being adversely affected by tobacco use. I understand that one of your primary focuses has been on the effects of illicit drug use among pregnant women. I would invite you, however, to consider the effects of a substance which is completly legal in this country, which is used by more than 25 percent of pregnant women and which has been scientifically demonstrated to have serious adverse side effects on the unborn fetus and neonate.

Smoking of tobacco during pregnancy is an important modifiable risk factor for low birthweight, [1,2] and is also correlated with increased risk of early fetal loss. [3,4] It is projected that if all pregnant women stopped smoking, the number of fetal and infant deaths would be reduced by 10 percent. [5] An estimate of the average cost of neonatal care is $189 higher (1983 dollars) for infants born to smokers. [6] Smoking in pregnancy has also been linked to postnatal complications. Smoking doubles the risk of Sudden Infant Death Syndrome (SIDS). [7]

Clearly, attention needs to be given to this problem and methods need to be developed that will help pregnant women quit smoking or a least reduce their consumption of tobacco during their pregnancy. Traditional smoking cessation programs generally utilize multiple educational sessions often spread over a time frame of several weeks. Such programs often impose time and transportation barriers to the pregnant population. Recently, there has been a significant trend toward the use of self-help materials for smoking cessation which can be utilized by an individual without the need for attendance at formal clinic sessions.

These techniques must rely heavily on the ability and motivation of the individual to read the self-help literature.
I would like to share with you an approach to overcoming these barriers which was utilized on a pilot basis in the Kent County Health Department WIC Clinic.

The Kent County WIC Clinic currently maintains an average monthly caseload of just over 6,000 clients. We are presently in the midst of expanding to serve an average montly caseload of 8,000. At this level we would anticipate approximately 4,000 pregnant women would utilize the WIC clinic over a 12 month period. Approximately 42 percent of pregnant women utilizing KCHD's WIC Program are current smokers. This compares with an estimated 32 percent of all women of child-bearing age who smoke.

During our pilot, 81 percent of the smokers identified agreed to participate. Participants were randomly assigned to one of three groups. The usual care (UC) group received printed information about the risks of smoking during pregnancy and completed the clinic in the traditional manner.

The multiple component (MC) group received a 20 minute one-to-one counseling session which included both risk information and behavior change components. The risk information component employed the Because I Love My Baby materials developed by the American Lung Association. These materials included a "flip chart" used by the health educator in presenting the information and a printed brochure given to clients to take home.

The behavior change component of the MC intervention employed a self-help manual adapted from Windsor, et al [5], and from the American Lung Association's Freedom From Smoking program. Behavioral contracting and self-monitoring were the primary strategies. An individual behavioral contract was developed during the session which specified a quit date and selection of some significant other as a co-signer. Self-monitoring included charts of recording daily smoking behavior, and the development of an individualized plan of action for breaking recorded behavioral chains.

The risk information (RI) intervention was a face-to-face session of about 10 minutes duration. The health educator used the same "flip chart" as the MC group and provided the factual brochures, but did not present behavior change counseling, or furnish the self-help manual.

Of the three groups, those clients receiving the MC intervention achieved the best results. The MC group had a quit rate of 11 percent.

Implementation of the MC methodology as a routine part of WIC care for all pregnant smokers would require the addition of professional staff at a cost of approximately $19,000. This is a relatively small amount of money when compared to our overall County WIC budget of approximately $686,500. Unfortunately, increases in WIC funding are always attached to requirements for increase in caseload thus making it impossible to add even a part-time staff resource to address this important area. Locally, we are already contributing more than $130,000 to the WIC budget just to meet the basic requirements.

I would also share with you the fact that similiar approaches have been tried in other local WIC programs in Michigan with less promising results. I believe it is important to understand some of the differences which led to better results in Kent County. First, our program delivered its intervention during the regular clinic visit. We would not have had an 81 percent participation rate if we had asked smoking WIC mothers to return for a separate session. Secondly, we utilized our own staff to deliver the intervention. A WIC clinic is an extremely busy and often confusing place. In order for smoking interventions to be truely integrated into the WIC program, it is essential that the entire clinic staff understand and be committed to the concept.

In summary, we have seen that smoking rates among pregnant WIC clinets exceeds the average rate of the population. There is no recruitment problem to get clients into the WIC program. In fact, we generally have a waiting list. Once in the WIC program a large percentage of smokers will agree to participate in a smoking intervention if offered and if it does not require an additional trip to the clinic. Brief smoking interventions (20 minutes or less) can be integrated into the WIC clinic flow with a minimal but critical addition to professional staffing levels. Such brief interventions can be demonstrated to produce quit rates in excess of 10 percent.

The WIC program should be expanded to include smoking interventions along with the nutrition education and provision of supplemental food that have proven so effective over the last 10 -15 years. The additional cost of these interventions should be recognized with appropriate adjustments to the local staffing grants. In Kent County we have had to interrupt our provision of this needed service while we pursue other funding mechanisms.

Thank you for your attention and consideration.

References

1. Institute of Medicine: Committee to Study the Prevention of Low Birthweight: Preventing Low Birthweight (Ch.2 & Appednix A), Division of Health Promotion and Disease Prevention. Washington, DC: National Academy Press, 1985.

2. Mullen P: Smoking Cessation Counseling in Prenatal Care." Washington. DC, 1989.

3. Kline J, Stein Z, Susser M, Warburton D: Smoking: A risk factor for spontaneous abortion. N Engl J Med 1977; 297:793-796.

4. Himmelberger DU, Brown BW Jr, Cohen EN: Cigarette smoking during pregnancy and the occurence of spontaneous abortion and congenital abnormality. Am J Epidemiol 1978; 108: 470-479.

5. Kleinman JC, Pierre MB Jr, Madans JH, Land GH, Schramm WF: The effects of maternal smoking on fetal and infant mortality. Am J Epidemiol 1988; 127: 274-282.

6. Oster G, Delea TE, Doldit: GA: The Effects of Cigarette Smoking during Pregnancy on the Incidence of Low Birth Weight and the Costs of Prenatal Care. Cambridge, MA: Institute for the Study of Smoking Behavior and Policy, Harvard University, 1986.

7. Haglund B, Cnattingus S: Cigarette Smoking as a Risk Factor for Sudden Infant Death Syndrome: A Population-based study. American Journal of Public Health 1990; 80:29-32.

STATEMENT OF JOYCE SCOTT, EXECUTIVE DIRECTOR, WEST SIDE FUTURE, CHICAGO, IL

Ms. SCOTT. Thank you. My name is Joyce Scott and I am the Director of West Side Future, which is one of the "Families with a Future" programs that was previously mentioned by Director Atkins.

We are a community-based and state-funded infant mortality reduction program. We originally received our funding in 1986. The overall purpose of the program is basically to attempt to lower the infant death rate in our particular community area, as a part of Illinois' statewide initiative to deal with this particular problem.

We have a wide range of services that we are responsible for either providing directly or linking to other service providers. We conduct outreach and identification within our service community. We refer clients and link them to other service providers. We provide case management and also basic concrete services, infant clothes, formula, cribs, that kind of thing.

One of the things that we began to discover when we went out with a very broad issue of lowering the infant death rate, when we got into our community—in this community, the population is very varied and diverse. We have 43 percent of our community area, which is the near west side of Chicago, that lives in public housing. We have three CHA or Chicago Housing Authority developments that are situated within our community. We have large numbers of institutions but we also have a very upscale housing segment and populations that we have to contend with where we have homes that may run as much as $250,000–$275,000 per unit.

One of the things that we immediately noticed from the inception of the program was that there was a previously unacknowledged problem with drug use. We were finding anywhere from 30 to 50 percent of our population that were either known or suspected drug and or alcohol abusers. Many of them were suspected, we were identifying them because they were eight, or nine months behind in their rent, they were constantly in our program sites seeking emergency food, emergency formula. One week after getting the WIC stamps, they would come in needing emergency formula for the baby and supposedly the baby would have used 31 cans of formula in seven days. So it was those kinds of things where we constantly had clients in that would make us begin to delve closer in terms of what the problem was.

Unfortunately, West Side Future was not alone in this realization. There are ten other networks within the city, 15 total within the state, and the same scenario was surfacing from all of those particular networks, i.e., that there is a major drug problem, and worse than that, there is a very real lack of treatment services in particular for pregnant women.

We became very adept at negotiating with physicians on getting drug treatment for women. Unfortunately at that time, the issue was you could get a woman admitted as an in-patient to a hospital for treatment only if there was a problem with the pregnancy. You could not go in with drugs or alcohol being the major issue. So we became adept at negotiating with service providers in terms of acquiring those services.

The other problem, along with lack of treatment, was the fact that we found we really needed to begin to change our focus. When we thought about what the needs were of the women, we had to look at family centered approaches, a lot of what you have heard here today. Our population is very young—our client stats indicate that 90 percent of the women we serve, and we currently maintain about 1200 open cases per year, 90 percent are 25 years and under.

What we found with many of these young women is that their initial introduction to drugs or alcohol was either through a husband or boyfriend. If they were not the precipitator, then generally they also had a drug or alcohol problem themselves. So if we went into that family seeking to acquire treatment just for the woman, we were guaranteed to be unsuccessful because half of that couple would not get services.

The other issue too was a lack of supportive services, i.e., child-care. In the rare instances we could get in-patient treatment, women could not utilize it because child-care could not be arranged or they had to be prematurely terminated because child-care plans fell through. We also found that to be a problem with out-patient services. As I stated, we have a very young population, many of them have several preschool children. So even when you talk about out-patient programs, and you are talking three, four, five hours per day, child care becomes a major and necessary need in terms of women accessing those particular services.

That is just a minor list of the type of supportive services that need to be focused on and coordinated when we are talking drug and alcohol treatment for women.

We are pleased though, as Director Atkins indicated, that the administrators in Illinois, the Department of Public Health, Alcoholism and Substance Abuse and the Department of Children and Family Services did listen to the service providers and we have recently received funds for the "Drug-Free Families with a Future" initiative. We have received funding to institute in each of the 19 communities in Chicago very specialized case management units whose primary focus will be women who are pregnant or parenting, who have drug and alcohol problems or who are HIV positive. They will remain in the program until they are drug or alcohol free. It is not related to the age of the infant, which is the case with our core population which we have to terminate once the infant reaches one year of age.

Another piece that we are very pleased with is that very soon, hopefully, the Department of Public Health will be authorizing the salary for a full time case manager at the Cook County Jail. Basically what has surfaced is that Cook County currently processes about seven to eight thousand women per year. Of that population, anywhere from four to five thousand are pregnant during any given year, and that is those that are clearly pregnant. If you tested for pregnancy, you would probably find the population would increase.

Right now the difficulty is, although they receive prenatal care in the hospital and most of them are in because of drug or drug related charges, once they are released, they are lost to the system for the most part. There is no way of tracking them. The proposed case manager's exclusive purpose will be to identify them and link

them back at the local level to West Side Future and its counterparts, to the specialized case management programs. And when they are not within one of our areas, because unfortunately we do not have comparable programs across the city, they will minimally be linked to medical care for prenatal services and to drug or alcohol treatment programs.

Basically, in particular at the local level, we have realized that in order to be in any way successful, we have to look at a very comprehensive and coordinated service delivery system. It takes time, it takes energy and it is difficult, but it is not impossible. Within our network we have written linkages with major health care providers, with small social service agencies, with schools, with churches and a variety of other institutions, and we clearly feel at the local level and also the administrative staff in Illinois, that this is one means of attempting to provide the kind of services that are needed by this population.

Mr. LEVIN. Who is next? Maisha Kenyatta is next on the list.

[Prepared statement of Joyce Scott follows:]

Prepared Statement of Joyce Scott, Director, West Side Future/YMCA of Metropolitan Chicago, Chicago, IL

It is a pleasure to speak with you this morning on the issue of treatment options for substance abusing pregnant and parenting women. My comments are derived from my experience as the Director of West Side Future, a division of the YMCA of Metropolitan Chicago, and fourteen years as a professionally trained Social Worker in community and institutionally based programs.

West Side Future is one of fifteen Infant Mortality Reduction Networks in the state of Illinois. We initiated services in June of 1986. This program, as is true with the others, is community and directed through the efforts of a variety of local service providers. We have three program sites that are based within the three public housing developments in our community. From the beginning, in our efforts to address the high infant death rate in our area, it became increasingly clear that an unacknowledged factor was operating. That was the high incidence of drug and alcohol use by the women we were attemping to serve. This was also surfacing within the other Networks in the state.

As West Side Future communicated its concerns to the Chicago Department of Health, the lead agency, and the Illinois Department of Public Health, the primary funder, we also raised the issue to the dearth of treatment programs directed towards pregnant, in particular, and parenting women. Treatment programs, for the most part, were unequipped to serve this population. There were the medical issues involved in providing drug or alcohol treatment to a woman who is pregnant and the multitude of supportive services that are needed to insure successful treatment.

As we worked with these families, several needs surfaced in addition to the lack of treatment services. One was that we must serve the "family" and not simply the identified female. In many instances, the young women were introduced to drug or alcohol by their partner. When that was not the case, often the partner was also an alcohol or drug abuser. Therefore, we would be assured limited success if we concentrated on "one-half" of the couple. Child care also surfaced as a major need. When we were able to arrange inpatient treatment, it was frequently not utilized or prematurely interrupted because of the lack of child care. Child care is also a concern with out-patient treatment. Many of these women are young and have several pre-school children. Therefore, child care was necessary to attendance at out-patient programs. These are simply some examples and does not include other needs, such as, short and long-tern housing.

I am pleased to report that Illinois administrators have responded to the concerns surfacing out of the local communities. All of the networks were recently funded to develop specialized Case Management units to serve pregnant and parenting women who are drug and alcohol "abusers" and those who are HIV positive. In concert with this funding, the Department of Alcohol an Substance Abuse has funded in-patient and out-patient treatment programs that exclusively serve pregnant and parenting females. The Department of Children and Family Services is also working collaboratively with Publics Health and DASA. In addition, they have committed child care dollars for the express use of women identified through this program.

Our intent is to provide services that protect the infant at the same time that we assist the mother and strenghten and support the family. The program has been designed in this manner to avoid a more punitive stance that ultimately drives these women and their families further "underground". As a continuation of this directive yet supportive programming, plans are currently in progress to fund a complimentary component at the Cook County Jail.

The Department of Public Health is planning to fund a full-time Case Manager who will be housed at the jail. Inmate statistics show four hundred pregnant women per year are processed. The majority of these women are in because of drug or drug-related charges. This figure represents those who can be readily identified as pregnant. The population might increase if pregnancy testing was done. Currently, a weekly prenatal clinic is operated. There is no means, at the present time, of following these women into their local communities to insure the continued provision of medical and drug or alcohol treatment. The planned Case Manager will provide this link. He/She will refer and facilitate the involvement of the women with the newly funded Case Management units. In areas where a unit does not exist, a referral will be initiated to a city Health facility and a substance abuse treatment provider .

The preceding synopsis of services is an indication of our committment to programs that have a treatment/support focus rather than that of punishment. I hope that this Body expresses its support of programs that will "assist" these women with their problem of drug or alcohol use rather than exascerbate the problems through incarceration and/or dismantling of their families.

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STATEMENT OF MAISHA KENYATTA, DIRECTOR, HOPE, UNITY AND GROWTH, INC., DETROIT, MI

Ms. KENYATTA. Mr. Chairman, members of the committee, I am Maisha Kenyatta, and I am Director of HUG—Hope, Unity and Growth, Inc.—here in Detroit. HUG is a residential substance abuse facility for women and their young children. We are located on the east side of Detroit in the heart of what is known as a drug-infested community. Our location allows addicts to have easy accessibility to treatment. Women seeking help can find the help they need in a familiar, yet protective, environment.

HUG opened in September of 1987 as a domiciliary facility for Eleonore Hutzel Recovery Center. We recognized the need for women to be able to take their children into residential treatment while they work on their recovery. Within a year, HUG expanded and became licensed by our Office of Substance Abuse Services as a substance abuse program for women and their young children. This expansion was due to an overwhelming request from female addicts to receive treatment at HUG, an ongoing waiting list at Eleonore Hutzel Recovery Center and the growing need in Detroit for more substance abuse programs for women.

Our residents are predominately black with limited income and resources. They are often unaware of the services available to them and how to receive those services. Therefore, an important part of our program is to promote independence and acquire networking skills. Through self-referrals to community programs, residents must arrange transportation for themselves and their children to all appointments. Thereby, they develop a working knowledge of services available to them.

Through a holistic treatment methodology, we promote balance in their lifestyles. Residents learn to avail themselves of the community. While in HUG, they may also participate in outside community programs. The residents are given passes to experience life outside of HUG's protective environment. The passes are a tool to enhance their coping skills. Re-entry into the community is done in stages which assists each person in realizing her strengths and weaknesses.

HUG provides a full range of therapeutic services to promote a drug-free lifestyle. These services include individual, family and group therapy, didactics and weekly support groups such as Narcotics Anonymous, Alcoholics Anonymous and Families Anonymous, implemented by trained professional and para-professional staff. To augment these services, we have created three unique programs:

The Buddy Program. Residents with at least 30 days of sobriety volunteer, with therapist approval, to help newcomers adjust to the program. A Buddy becomes a mentor in assisting newcomers in understanding the program structure.

Community Outreach. Upon completion of the program, residents voluntarily speak in community programs about chemical dependency. They share their journey, fights and accomplishments as they continue to recover. The community outreach premise is to give back what you have gotten.

Child Care Program. This is a program within HUG licensed by the Department of Social Services. Children participate in the program while moms engage in recovery activities. Parent skills classes are offered as a therapeutic component.

Through a grassroots approach, three social workers born and reared in Detroit began to provide substance abuse treatment, which was the origin of HUG. We began to work closely with people living in the community in identifying and addressing problems. Today, we have the support of more than a dozen community residents who volunteer their services. These include two physicians, a registered nurse-practitioner, a spiritual counselor, a psychologist, and educators, among others. They work with the residents on building every day living skills such as budgeting money, planning social outlets for moms and children, obtaining clothing donations, establishing households, et cetera. Families of residents are also encouraged to participate by joining this group or through Families Anonymous meetings.

A habit of healthy living is learned in a family-type environment. We emphasize the concept that HUG is a place to help addicts to help themselves recover. This is something no government regulation or requirement can ever hope to match. Our motto is, "The program works if you work it." In keeping with that, we believe each person is responsible for her own recovery. That is why we encourage them to participate in the total program.

Often, women come into the program with feelings of hopelessness. But as they hear the horror stories of other women and observe their growth, they begin to move toward an acceptance of the fact that there is hope for them to recover and recognize that in every moment of their lives, they can learn. For example, through their active addiction, they learned that drugs will only leave to death, destruction or insanity. Through their recovery process at HUG, they learn how to lead healthy lives.

Each resident contributes physically, spiritually and financially to the program. This promotes self-determination and responsibility. Residents learn that there are no free rides in life. They also learn to accept responsibility for themselves and their children. In our program, residents are involved in every aspect, which includes domestic organization and assisting with administrative decisions. This, we feel, enhances self-esteem and builds confidence as they make decisions with the staff regarding important aspects of the program.

We are proud of our program because it works for us in our community. HUG is a family-centered program with an emphasis on individual responsibility. Without the help of local people, who know the community and understand its needs, we could not hope to do as much as we are doing.

Of course, we welcome the interest and support of government in our program. But HUG and other local programs like it in neighborhoods across the country must have the freedom to meet community needs based on the community's situation. When the government imposes restrictions and requirements from above, those of us below cannot do our jobs effectively. We instead become too busy trying to please the government instead of helping who need it. So I would urge you, the Congress, to recognize that flexibility is

very important to us. In your urge to help us, please do not make the mistake of handcuffing us with rules, formulas and policies that sound good in Washington, D.C., but make no sense for neighborhoods like mine in Detroit, Michigan.

It is an honor to appear before you to tell you about HUG. Thank you.

Chairman MILLER. Thank you. Ms. Potti.

[Prepared statement of Maisha Kenyatta follows:]

Prepared Statement of Maisha Kenyatta, MSW, Director, Hope, Unity and Growth, Inc., Detroit, MI

Mr. Chairman and members of the Committee:

I am Maisha Kenyatta. I am director of HUG - - Hope, Unity and Growth, Inc. - - here in Detroit. HUG is a residential substance abuse facility for women and their young children. We are located on the east side of Detroit in the heart of what is known as a drug-infested community. Our location allows addicts to have easy accessibility to treatment. Women seeking help can find the help they need in a familiar yet protective environment.

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2. an ongoing waiting list at EHRC,
3. the growing need in Detroit for more substance abuse treatment programs for women.

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and resources. They are often unaware of the services available to them and how to receive those services. Therefore, an important part of our program is to promote independence and acquire networking skills. Through self-referrals to community programs, residents must arrange transportation for themselves and their children to all appointments. Thereby, they develop a working knowledge of services available to them.

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sobriety volunteer, with therapist approval, to help newcomers adjust to the program. A Buddy becomes a mentor in assisting newcomers in understanding the program structure.

- **Community Outreach:** Upon completion of the program, residents voluntarily speak in community programs about chemical dependency. They share their journey, fights and accomplishments as they continue to recover. The community outreach premise is to give back what you have gotten.
- **Child Care program:** This is a program within HUG licensed by the Department of Social Services. Children participate in the program while moms engage in recovery activities. Parent-skills classes are offered as a therapeutic component.

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life. They also learn to accept responsibility for themselves and their children. In our program, residents are involved in every aspect, which includes domestic organization and assisting with administrative decisions. This, we feel, enhances self-esteem and builds confidence as they make decisions with the staff regarding important aspects of the program.

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Of course, we welcome the interest and support of the government in our program. But HUG and other local programs like it in neighborhoods across the country must have the freedom to meet community needs based on the community's situation. When the government imposes restrictions and requirements from above, those of us below cannot do our jobs effectively. We instead become too busy trying to please the government instead of helping people who need it. So I would urge the Congress to recognize that flexibility is very important to us. In your urge to help us, please do not make the mistake of handcuffing us with rules, formulas and policies that sound good in Washington, D.C., but make no sense for neighborhoods like mine in Detroit, Mich.

It is an honor to appear before you to tell you about HUG, and I thank you for listening. I will be glad to answer any questions you may have.

STATEMENT OF LISA POTTI, MSW, PROGRAM COORDINATOR, MOTHER AND INFANT SUBSTANCE ADDICTION NETWORK, DETROIT HEALTH DEPARTMENT, DETROIT, MI

Ms. POTTI. I never thought we would get here.

My name is Lisa Potti, I would like to thank you all for asking me to be here today.

I am the Program Coordinator for the Mother and Infant Substance Addiction Network or MISAN, and I have been involved with the Detroit Health Department in various special infant mortality reduction programs which include the MICH-Care Program, which is a Medicaid enrollment for pregnant women, and the Prenatal Advocacy Project geared towards identifying hard to reach prenatals not receiving prenatal care.

The problem in the City of Detroit for pregnant, substance abusing women is not only a lack of available drug treatment facilities but also a lack of coordination between drug treatment, prenatal care, and health and human services. The Detroit Health Department's Mother and Infant Substance Addiction Network is a new federally funded Office of Substance Abuse Prevention, OSAP, Demonstration Project, designed to provide coordinated maternal and infant care with substance abuse treatment in the City of Detroit for 250 substance abusing pregnant women. The coordination of these two disciplines of service will be accomplished through a case management system focusing on providers in the public and private sectors. The goal to coordinate existing services is a way of providing comprehensive services at less cost.

The uniqueness of the MISAN project is the non-medical support services provided to women in the community through various public health programs that currently exist. The Mother and Infant Substance Abuse Addiction Network project does not provide substance abuse treatment, but instead supports the women's involvement in drug treatment with the Eleonore Hutzel Recovery Center. The prenatal support services that are available include: our paraprofessional outreach program which utilizes specially trained indigenous workers from the community who then provide support services to pregnant women and their infants up to age one; maternal support services utilizing a multidisciplinary team of professionals which include a social worker, public health nurse and a nutritionist that provide comprehensive services to Medicaid eligible pregnant women and infants; public health nursing services which provide professional nursing services to clients and their families in their homes and the community; and children's special health care services providing a community based approach to identifying the needs of the chronically ill child, handicapped children and their families.

In addition to these comprehensive maternal child health programs, all clients have access to the array of public health services available, which include, but are not limited to our family primary care health clinics, our MICH-Care program, healthy baby van for transportation, well baby care, the AIDS project, family planning, laboratory services, lead poisoning, et cetera.

The critical difference this program can make is that it offers current programs a better opportunity to interface and to provide services to women and infants who have a compiex array of problems.

Infant mortality is a social problem with health consequences. These problems include substance abuse, poor nutrition, poverty and access to prenatal care, and they all need to be addressed together. The commitment to universal access to care requires existing programs to expand as well as the creation of new programs. Justifiably, there is widespread concern among health care providers, policy makers and clients alike, that substance abuse during and after pregnancy is contributing to the high rate of infant mortality in Detroit. In 1977, the rate of live births per 1,000 to drug using mothers was 11.9 and in 1988, that same rate almost tripled to a high of 30.6 per 1,000 live births.

In an effort to help reduce the high death rate in the City of Detroit, there is a need to identify the substance abusing population, coordinate and provide maternal and infant care services, increase education efforts of child-bearing females as to the negative effects of substance abuse during pregnancy, and also to target education efforts. The MISAN project intends to meet all of these objectives. As we begin our MISAN project, we are also seeking additional support from the Office of Substance Abuse Prevention to expand the project, which would include enrolling 100 substance abusing pregnant adolescents in drug treatment at Riverview Hospital. Currently, no drug treatment facilities exist for substance abusing pregnant adolescents in the city. Secondly, we would like to enroll an additional 100 substance abusing pregnant women in Samaritan Health Center for their chemical dependency treatment, thus making an additional 100 chemical dependency treatment positions available for women in the city.

MISAN's final effort in expanding treatment options is working with the private and public substance abuse treatment facilities. These facilities currently servicing women need to continue to provide drug treatment services to women who become pregnant while enrolled in their program as well as potentially accepting new substance abusers. The MISAN project hopes to support the pregnancy concerns of these women and will facilitate their prenatal care appointments. It is the project's intent that by providing prenatal support services as required, that drug treatment programs will feel more comfortable in maintaining and/or providing drug treatment for these women.

The demand for prenatal care and chemical dependency treatment in Detroit is great. Waiting times to access prenatal care for the month of April, 1990 reflects one to ten week waits for an initial prenatal care appointment. Averaging 4.2 weeks, this initial prenatal appointment oftentimes does not include a physician or nurse-midwife examination. This examination is scheduled approximately within two weeks after that initial appointment. Total waiting time, therefore, from a telephone call to seeing a physician can be three to 13 weeks. Hutzel Hospital's High Risk Clinic averages seven to eight weeks for a prenatal appointment. These high-risk

appointments are for substance abusing women, women with serious medical complications and for women who have waited to receive prenatal care until during or after their seventh month of pregnancy. These women cannot afford to wait seven to eight weeks for care. A substance abusing woman who seeks prenatal care during her seventh month may not actually have a physician appointment until after her baby has been born.

The Mother and Infant Substance Addiction Network will make a difference. The project will make a personal contact with a woman seeking services, provide what is needed, continue to support her emotionally and to facilitate the likelihood that she will indeed become enrolled in prenatal care and substance abuse treatment. These same options are available in other communities. We feel confident that this model offers immediate solutions for women in need of services as we speak. A woman has only one chance to grow her baby and we need to provide services during this window of opportunity. Communities need to support and link what resources are currently available while advocating for the expansion of new programs.

I thank you.

Chairman MILLER. Thank you. Ms. Johnson.

[Prepared statement of Lisa Potti follows:]

PREPARED STATEMENT OF LISA A. POTTI, MSW, PROGRAM COORDINATOR, MOTHER AND INFANT SUBSTANCE ADDICTION NETWORK (MISAN), DETROIT HEALTH DEPARTMENT, DETROIT, MI

I would like to thank you for the opportunity to testify before this committee.

I am the Program Coordinator for the Mother and Infant Substance Addiction Network (MISAN) and have been involved with Detroit Health Department in various special infant mortality reduction programs including the MICH-Care Program, which is Medicaid enrollment for pregnant women, and the Prenatal Advocacy Project geared towards identifying hard to reach prenatals not receiving prenatal care.

The problem in the City of Detroit for pregnant substance abusing women is not only a lack of available drug treatment facilities but also a lack of coordination between drug treatment, prenatal care, and health & human services. The Detroit Health Department's Mother and Infant Substance Addiction Network (MISAN) is a new federally funded Office of Substance Abuse Prevention (OSAP) Demonstration Project designed to provide coordinated maternal and infant care with substance abuse treatment in the City of Detroit for 250 substance abusing pregnant women. The coordination of these two disciplines of service will be accomplished through a case management system focusing on providers in the public and private sectors. The goal to coordinate existing services is a way of providing comprehensive services at less cost.

The uniqueness of the MISAN project is the non-medical support services provided to women in the community through various public health programs that currently exist. The Mother and Infant Substance Abuse Addiction Network (MISAN) project does not provide substance abuse treatment but instead supports the women's involvement in drug treatment with the Elenore Hutzel Recovery Center. The prenatal support services that are available include:

Paraprofessional Outreach Program - which utilizes specially trained indigenous workers from the community who provide support services to pregnant women and their infants up to age one.

Maternal Support Services - utilizing a multidisciplinary team of professionals including a Social Worker, Public Health Nurse, and Nutritionist that provide comprehensive services to Medicaid eligible pregnant women and infants.

Public Health Nursing Services - that provide professional nursing services to clients and families in their homes and the community.

Children Special Health Care Services - providing a community-base approach for identifying the needs of chronically ill and handicapped children and their families.

In addition to these comprehensive maternal child health programs, all clients will have access to the array of public health services available which include:

Family Primary Care Health Clinics
MICH-Care, Medicaid enrollments for prenatal/delivery care
Health Baby Van - Transportation Project
Well Baby Care
AIDS Project
Family Planning
Laboratory Services
Lead Poisoning, etc,

The critical difference this program can make is to offer current programs a better opportunity to interface and to provide services to women and infants with a complex array of problems.

Infant mortality is a social problem with health consequences. These problems include substance abuse, poor nutrition, poverty, and access to prenatal care all need to be addressed together. The commitment to universal access to care requires existing programs to expand as well as the creation of new programs. Justifiably, there is widespread concern among health care providers, policy makers, and clients alike, that substance abuse during and after pregnancy is contributing to the high rate of infant mortality in Detroit. In 1977, the rate of live births per 1,000 to drug using mothers was 11.9 and in 1988, the same rate almost tripled to a high of 30.6 per 1,000 live births.

In an effort to help reduce the high death rate in the City of Detroit, there is a need to identify the substance abusing population, coordinate and provide maternal and infant care services, increase education efforts of childbearing females as to the negative effects of substance use during pregnancy, and target prevention education efforts. The MISAN project intends to meet all of these objectives. As we begin our new MISAN project, we are also seeking additional support from the Office of Substance Abuse Prevention to expand the MISAN Project by:

1. Enrolling 100 substance abusing pregnant adolescents in drug treatment at Riverview Hospital. Currently, no program exist for substance abusing pregnant adolescents in the City of Detroit.

2. Enrolling 100 substance abusing pregnant women in Samaritan Health Center for chemical dependency treatment, thus, making available an additional 100 chemical dependency treatment positions for women.

MISAN's final effort in expanding treatment options is working with private and public substance abuse treatment facilities. These facilities, currently serving women,

need to continue to provide drug treatment services to women who become pregnant while enrolled in their program as well as potentially accepting new pregnant substance abusers. The MISAN project hopes to support the pregnancy concerns of these women and will facilitate prenatal care appointments. It is the project's intent that by providing prenatal support services, as required, that drug treatment programs will feel more comfortable in maintaining and/or providing drug treatment for these women.

The demand for prenatal care and chemical dependency treatment services in Detroit is great. Waiting times to access prenatal care for the month of April, 1990 reflects 1 - 10 week waits for an initial prenatal appointment. Averaging 4.2 weeks, this initial prenatal appointment often times does not include a physician/nurse - midwife examination. This examination is scheduled approximately within two weeks after the initial appointment. Total waiting time, therefore, from telephone call to seeing a physician can be 3 - 13 weeks. Hutzel Hospital's High Risk Clinic averages 7 - 8 weeks for a new prenatal appointment. These high-risk appointments are for substance abusing women, women with serious medical complications, and for women who have waited to receive prenatal care during or after her seventh month of pregnancy. These mothers can not afford to wait seven to eight weeks for care. A substance abusing woman who seeks prenatal care during her seventh month may not actually have a physician appointment until after her baby has been born.

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Thank you.

DETROIT HEALTH DEPARTMENT
MOTHER & INFANT SUBSTANCE ADDICTION NETWORK
(MISAN)

Herman Kiefer Health Complex
1151 Taylor Street
Detroit, Michigan 48202
(313) 876-0356

Darlinda Smith-VanBuren
Health Care Administrator

Lisa A. Potti
Project Coordinator

THE MOTHER & INFANT SUBSTANCE ABUSE NETWORK (MISAN)

The Detroit Health Department's Mother & Infant Substance Abuse Network (MISAN) will provide a model continuum of care designed program to coordinate maternal and infant care with substance abuse treatment in the City of Detroit for 250 substance abusing pregnant women. The coordination of these two (2) disciplines of service will be accomplished through a case management system focusing on providers in the public and private sectors. The objectives to achieve this project are:

1. Increase the rate of identification and referral of pregnant women in private substance abuse treatment programs by twenty percent (20%) in the first program year.

2. Identify and enroll a minimum of twenty-five percent (25%) of the program participants during their first trimester in the first program year.

3. Provide substance abuse prevention, early and continuous prenatal care, infant care and child growth and development education to one hundred percent (100%) of the program participants in the first program year.

4. Provide clinical substance abuse treatment aimed toward becoming drug-free to fifty percent (50%) of program participants in the first program year.

5. Provide consultation and referral to all program participants regarding subsequent pregnancies and life options, e.g., education and career planning, during the first year postpartum.

6. Refer and enroll all infants in preventative child care programs such as: Well Baby Care, High-Risk Baby programs, Early Periodic Screening Diagnoses and Treatment (EPSDT) Screening, Special Child Health Needs programs (Crippled Children), and Women Infant Care Nutrition Program (WIC), during the postpartum period.

7. To provide, during the second program year, follow-up services and develop support systems for all program participants and their infants in order to assist in the resolution of health problems during the first year postpartum period.

8. Develop specially trained public health professionals and paraprofessionals to provide specialized health care services to program participants within ninety (90) days of program commencement.

The drug treatment component of care for these women will be provided by the Eleanore Hutzel Recovery Center.

Eleonore Hutzel Recovery Center: This facility is unique in the City of Detroit because it is the only drug treatment center that combines substance abuse treatment and prenatal care. Major services the center provides to pregnant patients include: high-risk prenatal and postpartum care, preparation for baby and support for drug abstinence, individual counseling and/or therapy; methadone maintenance, group program (including prepared childbirth, parenting support for abstinence; AIDS risk reduction education, nutrition, work on self-esteem); detoxification from methadone after delivery for appropriate clients, etc.

In addition to drug treatment services, the Detroit Health Department will provide through its prenatal care clinics and various Maternal Child Health programs the following: prenatal, postnatal and infant care; family planning; paraprofessional outreach; maternal support services; services to children with special health needs; Women, Infants and Children (WIC); immunizations; Medicaid enrollment and screening; pregnancy testing; Public Health Nursing; nutrition; and referral for speciality services.

Maternal Child Health services unique to the Detroit Health Department are: paraprofessional outreach, public health nursing, maternal support services, children's special health care services and Project KIDD (Keep Infant Deaths Down). Each of the above mentioned program services are listed.

Paraprofessional Outreach Program: Specially trained indigenous workers provide supportive services to pregnant women and their infants up to one (1) year of age. They also perform casefinding and are teachers and resource linkers and outreach workers. Such services are free to clients.

Public Health Nursing Services: Consists of Public Health Nurses who provide professional nursing services to clients and families in their homes and the community. The services are preventive in nature and include health care education designed to prevent communicable diseases; encourage adequate nutritional intake, assess and instruct clients to maintain a safe environment; instruct parents to recognize the growth and developmental milestones of infants and children; assess and refer for warranted mental health services and/or other medical services. The Public Health Nurses continue to work with the Department of Social Services in the prevention and/or identification of child abuse and neglect.

Maternal Support Services: is non medical in nature and consists of multidisciplinary teams of professionals (Public Health Nurses, Social Workers, and Nutritionists) which provide comprehensive preventive services to medicaid eligible and medically indigent pregnant women and their infants. The services are offered to the high risk population up to sixty (60) days after the delivery, upon the receipt of a physician/nurse midwife referral. Services are provided in the Detroit Health Department clinics or client's homes, based on the provider's discretion. The services include: psychosocial/nutritional assessment, health counseling, transportation, child birth education and parenting and emotional support, and referral to appropriate community resources.

Children's Special Health Care Services provide a community-based approach for identifying the needs of the chronically ill and handicapped children and their families. Once identified, services include referral and case management for clients in need of and qualified (DSS Guidelines) for medical and corrective health care services.

Project Keep Infant Deaths Down (Project KIDD): Consists of a multidisciplinary teams of professionals (Pubic Health Nurses, Social Workers, and Nutritionists) who provide health assessment, counseling and referral services to women of child bearing age and prenatals. These services are designed to impact on the excessively high (23 deaths/1000 live births) infant mortality rate in a geographic section of Detroit. The prenatal health care instructions, nutrition counseling, family planning services, infant and child care instructions, immunizations, and social services are avilable to the at risk females regardless of their medical providers (public or private) at no cost to the client.

The Mother & Infant Substance Abuse Project will be evaluated by measuring: (1) successful identification and enrollment of new clients during the first trimester, (2) continued involvement in case management services at birth and one year later, and (3) reductions in substance abuse and improved pregnancy outcomes.

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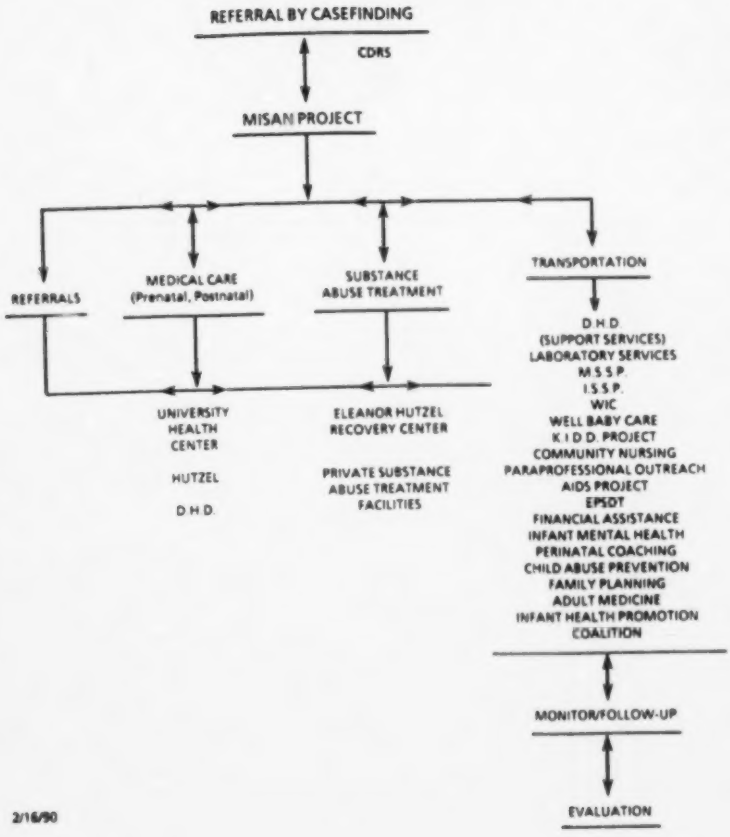
DETROIT HEALTH DEPARTMENT
MOTHER & INFANT SUBSTANCE ABUSE NETWORK
SERVICE DELIVERY MODEL



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The Detroit Health Department's Mother and Infant Substance Addiction Network (MISAN) is a new federally funded OSAP Demonstration Project designed to provide coordinated maternal and infant care with substance abuse treatment in the City of Detroit for 250 substance abusing pregnant women. The coordination of these two disciplines of service will be accomplished through a case management system focusing on providers in the public and private sectors.

The uniqueness of the MISAN project is the non-medical support services provided to women in the community through various public health programs that currently exist. The MISAN project does not provide substance abuse treatment but instead supports the women's involvement in drug treatment with the Eleonore Hutzel Recovery Center. The prenatal support services that are available include:

Paraprofessional Outreach Program - which utilizes specially trained indigenous workers from the community who provide support services to pregnant women and their infants up to age one.

Maternal Support Services - Utilizing a multidisciplinary team of professionals including a Social Worker, Public Health Nurse and Nutritionist that provide comprehensive preventive services to medicaid eligible pregnant women and infants.

Public Health Nursing Services that provide professional nursing services to clients and families in their homes and the community.

Children Special Health Care Services providing a community-based approach for identifying the needs of chronically ill and handicapped children and their families.

In addition to these comprehensive maternal child health programs all clients will have access to the array of public health services available which could include:

Family Primary Care Health Clinics
MICH -Care, medicaid enrollment for prenatal / delivery care
Healthy Baby Van-Transportation Project
Well Baby Care
AIDS Project
Family Planning
EPSDT
Laboratory Services
Lead Poisoning, etc.

The critical differences this program can make is offering the currently existing programs a better opportunity to interface and provide services to a complex problem with solutions.

Infant mortality is a social problem, with health consequences. These problem including substance abuse, poor nutrition, access to prenatal care have solutions. the commitment to universal access to care requires existing programs to expand. The MISAN project has been involved in finding additional options for drug treatment to meet the demand for services placed upon the EHRC. A new OSAP proposal submitted by the DHD would include:

(a) Enrolling 100 substance abusing pregnant adolescents in drug treatment at Riverview Hospital. Currently no program exist for substance abusing pregnant adolescents in the City of Detroit.

(b) Enrolling 100 substance abusing pregnant women in Samaritan Health Center for chemical dependency treatment thus, making available an additional 100 chemical dependency treatment positions.

MISAN's final effort in expanding treatment options, is working with private substance abuse treatment facilities. These facilities, current serving women, need to continue to provide drug treatment services to those women even if they become pregnant while enrolled in their program. The MISAN Program hopes to support the pregnancy concerns of these women and will facilitate prenatal care appointments. It is the project's hope that by providing prenatal support services, as required, that drug treatment programs will feel more comfortable in maintaining these women in drug treatment.

The demand for prenatal care and chemical dependency treatment in Detroit is great. The MISAN project may not be able to reduce waiting times for prenatal care or for drug treatment however, the project's intent is to make a personal contact with a women seeking services, to provide what is needed to continue to support her emotionally and facilitate the likelihood that she indeed is enrolled in prenatal care and substance abuse treatment.

STATEMENT OF CHARLENE JOHNSON, PRESIDENT AND CHIEF OPERATING OFFICER, REACH, INC., DETROIT, MI, ACCOMPANIED BY REV. LEE A. EARL, PASTOR, TWELFTH STREET BAPTIST CHURCH AND CHAIRMAN OF THE BOARD, REACH, INC., DETROIT, MI

Ms. JOHNSON. Thank you.

I think it is very appropriate that we conclude these hearings with the testimony from a group of people that has a prevention model to substance abuse, and we are very happy to share that with you.

My name is Charlene Johnson and I serve as President and Chief Operating Officer of REACH. REACH is a non-profit community development corporation which grew out of a ministry at Twelfth Street Baptist Church. I will be sharing with you today from two perspectives; one of a black woman, a female head of a household with four children, who grew up in the City of Detroit and who experienced first-hand the struggles inherent in racism, sexism, joblessness, poor quality education, substandard housing, crime, drug abuse, and family and neighborhood disintegration. And the other perspective is from one who chose not to allow these factors to overcome her, but rather to use these experiences as tools in helping us to develop a grassroots community development approach to substance abuse prevention.

We see substance abuse as symptomatic of some very complex environmental and social factors in our society. Substance abuse has to be fought by all of us and each of us has a particular role to play.

At Twelfth Street Baptist Church, REACH and the members of the Pilgrim Village community, we have formed a model that can be duplicated. This movement is deeply rooted in Christian principles and supported by the efforts of many. It is based on the belief that God created this world to reflect himself and provide for his creation. We, as believers, must do our part in preserving a world and ecological order that enhances and promotes life. Now if that sounds like something that comes from a Baptist preacher, it does, and he is here with me, Reverend Lee A. Earl. A lot of this is a combination of his thinking and his philosophy and theology as well as the programmatic and practical realities of the work that we do.

The underlying motive for the organization of REACH was the spiral of community decay which involved the exodus of the most socially and economically stable families in our community, the immigration of renters, the introduction and the rapid growth of the illegal drug trade and the increase in joblessness, crime and other social problems which accompany such a market. As founders of REACH, we saw these problems as interdependent. As such, resolution of any one of them relies on the resolution of the others. Thus, the REACH action plan is built upon a model of community development which empowers individuals in the community. A guiding philosophy, principle of the program is that the community must develop its own indigenous institutions and skills necessary to solve its own problems.

At its inception, REACH developed programs to address both the elimination of the drug market in Pilgrim Village and the reduction in family and individual risk factors for substance abuse.

The church is vital in this effort, but it is not the only sector that must participate. We must reach out and work cooperatively with other people of good will. We must help design and support programs that address the needs and problems of the immediate victims of the drug trade and abuse. Most of us agree on the objective of ridding our society of drugs. The problems arise in the strategy and approach.

We believe, and figures support—and we should indicate at this point that President Bush has named REACH the tenth point of light in his program to name all volunteer grassroots organizations, his 1,000 lights program, that Harvard University has come and has studied our program, that Senator Riegle and Senator Levin, other government officials have been and looked at this model and that we have received the kind of support that we need to continue it.

But we believe that programs must reflect the thinking of the people facing and fighting the problem daily, that participants in the programs must feel a sense and control and ownership of the effort, that those who control the resources must be willing to relinquish some of their control and that programs must enhance self-esteem and not innocently or well-intentionally destroy it.

Our view or our philosophy is holistic and comprehensive. We believe that real solutions must address the drug problem on all fronts at the same time. That is why REACH has developed programs in four particular areas. In the area of youth and family development, in the area of abandoned housing acquisition, rehab and resale, and neighborhood revitalization, in the area of our residents who demonstrate on a monthly basis and march against crack and crime, in the area of small business development. Traditionally our program has not been seen as substance abuse prevention, but more and more people are recognizing that this approach is necessary. As a matter of fact, the only drug specific program that we have is an NA meeting and a Pilgrim Village basketball association which attracts young people to the church wherein we work with them to help them improve their self-concept.

We have been providing jobs, housing, education, counseling, parenting, child care, skill training, food, economic development programs, all at the same time. We cannot provide one without doing the other. The significant absence of any weakens and impoverishes all victims, giving opportunity for the enemy to start the vicious cycle of doom and destruction.

The question was raised here earlier in the first panel, what will the women do once they leave these treatment programs. And our answer to that is that we have to develop the kind of communities, the kind of families, the kind of homes that these women can come back to and live productive lives. We see that welfare in its current state robs us of that opportunity. We are looking for a hand-shake from the government, not a hand-out.

In keeping with our philosophy of self-sufficiency and self-control, we have developed programs that will generate program income to help us continue the work. These funds can then be used

as we see necessary. There are two key programs in that effort. The first is our abandoned housing acquisition, rehab and resale program that generates cash flow. In this program REACH is holding mortgages on houses that we renovate and resell. Thereby we can earn interest on those notes receivable to help us in our program.

A second program that generates income is the development of small businesses. REACH has renovated several commercial buildings and then has helped to form business ventures that will lease those buildings from REACH and operate within the community, hiring community residents and empowering our people within the community.

Another program that we are currently forming is the extended family home. This is a pilot project which will work to house young, single mothers and their families while these mothers prepare for future employment and economic independence. We are in the process now of recruiting young women from shelters and also homes for unwed girls and we will provide a supportive living environment for these women in which to become socially and economically independent.

I have been asked to comment on the use of federal dollars and I would just like to show as a sample, this application for federal funding to the Office of Substance Abuse Prevention. I am not sure how many pages long it is, but it is quite a document for a grassroots organization to have to produce. We have found that getting federal funding is a most difficult process, and then once we receive federal funding, it is an even more difficult process trying to follow the rules and regulations that are inherent in the guidelines. Oftentimes these guidelines prevent us from delivering services to the people who are most in need. If it was not for Wayne State University's Office of Addiction Research, we probably would not have been able to produce this type of document. But we recognize that we need partnerships with the federal government, with the universities, with medical institutions, with businesses and so forth in order for the community to get the job done.

I would like to conclude with recommendations. We recommend the involvement of everyone, churches, community based groups, individuals, public and private sectors must form partnerships. Government must play the role of facilitators and moderators of the prevention process, not owners, operators and controllers. Programs must be designed by those who work from practical experience and not just theory. People must be placed in responsible positions based on merit and proven commitment. Resources must be allocated to wage a serious counter-attack.

In closing, I would just like to make a personal statement regarding Pastor Earl, he is my pastor at Twelfth Street Baptist Church and I think that the discussion earlier about women and our needing to be involved in the decision-making regarding our lives and our needing to make a contribution and having some self-worth is a very critical discussion. He has given women the opportunity to use our skills in the black Baptist Church, and it is rather unusual for that to happen. So we want to thank him for that.

And as a testament to that, this morning's FREE-PRESS in the business section has an article. It is a profile of me as the President of REACH, not a profile of the pastor as pastor of the church, al-

though he did have one in the newspaper a few months ago. [Laughter.]

But I think that women have to be involved in planning, and in delivering services to other women. It is just critical for that to happen. We make every opportunity for that to happen at REACH, and for women to feel that they are valued and that they have some worth and that even though we are all appendages, I use this statement that sometimes we can be made to feel that an appendage is less than rather than a part of a whole body. All of us are necessary, needed, valuable, and have to make a contribution in order for the whole body to work.

Thank you.

[Prepared statement of Charlene Johnson follows:]

PREPARED STATEMENT OF CHARLENE JOHNSON, PRESIDENT AND C.O.O., REACH, INC., ACCOMPANIED BY THE REV. LEE A. EARL, DETROIT, MI

My name is Charlene Johnson. I serve as President and C.O.O. of REACH, Inc., a nonprofit community development corporation, organized in 1986 as a continuation and expansion of the Outreach Ministry of Twelfth Street Missionary Baptist Church. I will be sharing with you today from two perspectives- one of a black woman, female head of household with four children, who grew up in the City of Detroit, AND who experienced first hand, the struggles inherent in racism, sexism, joblessness, poor quality education, substandard housing, crime, drug abuse, and family and neighborhood disintegration; and from the perspective of one who chose not to allow these factors to overcome her, but rather, use these experiences as valuable tools in assisting in the development of a comprehensive community development approach to substance abuse prevention.

There is an enemy in our land waging a new form of warfare that attacks and destroys the very fiber of our society. It's first victims are the weakest and most impoverished members of our communities. The poor, the children, the unemployed, the aged and their families and institutions. To be sure, this enemy will not stop at this level. It will continue its destruction into all races, classes and homes. The counter-attack will demand an all out effort by each person and sector of our country.

The counter-attack, being launched by Twelfth Street Missionary Baptist Church, REACH, Inc., and members of the Pilgrim Village community is an example that can be duplicated. It is a movement deeply rooted in Christian principles and supported by the efforts of many. It is based on the belief that God created this world to reflect himself and provide for his creation. We, as believers, must do our part in preserving a world and ecological order that enhances and promotes life.

The underlying motive for the organization of REACH was the spiral of community decay which involved the exodus of the most socially and economically stable families, the immigration of renters, the introduction and rapid growth of an illegal drug market and the increase in violence, crime, and other social problems which accompany such a market. As founders of REACH, we saw these problems as interdependant. As such, resolution of any one of them relies on the resolution of the others. Thus, the REACH action plan is built upon a model of community development. A guiding principle of the program is that the community develop its own indigenous institutions and skills necessary to solve its own problems.

At its inception, REACH developed plans to address both the elimination of the drug market in Pilgrim Village and the reduction in family and individual risk factors for substance abuse. The goal was to develop a system of services to address the multiple risk factors which characterized the community.

The church is a vital part, but not the only sector that must participate. We must reach out and work cooperatively with other people of goodwill. We must help design and support programs that address the needs and problems of the immediate victims of drug trade and abuse. Most of us agree on the objective of ridding our society of drugs. The problems arise in strategy and approach.

We believe, and figures support, that we are having some success. We have seen crime drop in our area since we began to fight back. There are certain non-negotiable elements that facilitate accomplishment:

1. Programs must reflect the thinking of the people facing and fighting the problems daily. These are the real authorities, the people who are and have been there. They know the enemy first hand. They must be involved in the design of programs.

2. Participants in programs must feel a sense of control and ownership of the effort. When solutions are created without their direct involvement, they become suspicious and resentful. We must allow people to solve their own problems and fight their own battles.

3. Those who control the resources must be willing to relinquish some of their control. The means used to gain control of these resources does not automatically qualify one as an authority on their highest and most effective use.

4. Programs must enhance self-esteem and not innocently or well-intentionally destroy it. We can't insinuate blame on the victim by adopting a prejudicial attitude. "If you knew the answer, you wouldn't have the problem" mentally won't work. It's becoming more apparent that the so-called answers are obviously for some other problem. The answers that we see coming into our communities, rather than out of our communities are not working.

Our view or philosophy is a holistic, comprehensive approach. We believe that real solutions must address the drug problem on all fronts at the same time. People need jobs, housing, education, counseling, coaching, child care, health care, skill training and food at the same time. We can't provide one without the other. The significant absence of any, weakens and impoverishes all victims, giving opportunity to the enemy to start the vicious cycle to doom and destruction.

However, REACH, in keeping with its philosophy of self-sufficiency and self control, is developing programs which will generate program income. These funds can be used as we see necessary. Two key programs in this endeavor are the housing program and the development of business ventures. The housing program generates cash flow from the sale of houses which is recycled to continue the program. Additionally, REACH holds the mortgage on some of the houses sold. Thereby earning interest on the notes receivable on these mortgages.

The Extended Family Home will house young single mothers and their families while the mothers prepare for future employment and economic independence. The special problems of families with young single mothers increase the risk of substance abuse for both the mother and the child. The operational goal of the Extended Family Home is to provide the economic and social support necessary for the families to become economically independent.

To be eligible for the program, mothers must be actively enrolled in an educational program such as high school, GED training, college or vocational school. Mothers will also be required to participate in the parenting trainings, family activities and the drug education classes offered by the "Youth and Family Development Program". Rent and child care will be subsidized by the Aid to Families with Dependent Children program for which the minimum age of eligibility is 17. Consequently, the minimum age of eligibility for the Extended Family Home will be 17. Because the target population of the Home is young single mothers, the maximum age of eligibility will be 23 years. These age restrictions will apply at the time of admission into the program only; women who celebrate their 24th birthday during their tenure will remain eligible (as long as they meet the other program requirements) until they successfully complete their education. The home will house up to five single parent families who will provide mutual support under the guidance and supervision of a live-in housemother.

The Extended Family Home will be prepared for occupancy and the housemother will be hired by the end of the first quarter of Year 1 (10/1/90 - 12/31/90). Service will begin at the earliest possible date, no later than 1/1/91. The goal of the Home is to facilitate the establishment of economic independence for a minimum of five families.

Most of our other programs provide opportunities for participants to give back to the program to keep programs on-going and also provide opportunities to leverage and increase grant dollars, rather than just using them up and not receiving any continuing benefit from the grant. We see this component of our programs as critical to the development of appropriate attitudes of responsibility, involvement, control and self-worth of individual participants.

REACH has been awarded federal, state, and foundation funding for several of its programs. Of all the sources, federal funding is the most difficult to apply for and actually use. Federal funding involves:

1. Lengthy and highly technical applications;

2. Lengthy approval and fund release process;

3. Rules and regulations in performance contracts that are inconsistent with efficient service delivery;

4. Extra layers of bureaucratic, inter-mediary monitors, etc., who hamper service delivery; and

5. Too many restrictions, doesn't allow enough flexibility to meet the needs of people.

State and foundation funding is a lot easier to access and use.

We strongly recommend the involvement of everyone. Churches, community based groups, individuals, public and private sectors MUST form partnerships. Government MUST play the role of facilitators and moderators of that process, not owners, operators, and controllers. Programs MUST be designed by those who work from practical experience, not just theory. People MUST be placed in responsible positions based on merit and proven commitment. Resources MUST be allocated to wage a serious counter-attack.

Our political construction and religious foundation call for the same and -- life, liberty, and the pursuit of happiness by all -- even the poor and the weak. Our nobility as a human race demands our care for the weak by the strong. Our times demand unity of purpose and efficiency of action. Our enemy demands that each person stand and give their best.

Chairman MILLER. Who is the preacher here? [Laughter.]

You are about to lose your job. Thank you very much for all of your testimonies.

I recognize Congressman Levin.

Mr. LEVIN. Thank you, Mr. Chairman, and welcome to all of you. Maybe if I might say so, especially to those of you who grew up or have been living where I grew up, some years ago.

I will just say one thing briefly if I might and then I need to leave, my colleagues will finish up in the next few minutes.

I was struck by Ms. Potti's reference to the lack of any residential facility for adolescent women who have an addiction problem. With all of our emphasis on adolescent pregnancy in our society, I think it is striking to note that in this area there is not a single one, and as much good work as has been undertaken here and within the church, we still have that far to go. I think what we need to do from this hearing is to learn that there are some successful models and we just need to get on with it.

By the way, as I leave, maybe if you do not mind, you would send to me a copy of your—of the grant application. For the first time in this decade——

Chairman MILLER. You will have to check it, you will not be able to carry it on.

Mr. LEVIN. They will mail it before the post rates go up.

You know, for the first time in a number of years, there is now a new grant program. Since you and I came to the Congress, and I think you, Clyde, there is now some new money available in a grant program to local communities and to states and all of us at this table want to make sure that that is workable and working. So if you do not mind, send it to me. I would like to see what it looks like. I have been encouraging the communities in the 17th District to get busy and get at it and I want to make sure that there is not too much paperwork here.

Anyway, thank you so much to each and every one of you from Grand Rapids through Illinois back here in Detroit for your excellent testimony.

Chairman MILLER. Thank you.

Mr. LEVIN. I was going to ask, how many HUGs do we need in Detroit?

Ms. KENYATTA. A million.

Chairman MILLER. Daily. Ms. Potti, let me ask you something. You said that you had worked out an arrangement with private physicians. Do you actually have commitments from private physicians who will provide treatment for——

Ms. POTTI. What we have done is we have spoken with several private substance abuse facilities; Project Life, Metro East, and have asked them if we were to support the pregnancy concerns of the woman, help facilitate her getting into treatment, would that in any way raise your comfort level in providing drug treatment services, and they have said yes. We are in the middle of drawing some protocols now and starting to receive some referrals from those facilities as we speak.

One of the other things that is interesting that is occurring is women are oftentimes screened for pregnancy when they enter substance abuse treatment and then are never screened again. And

as the period of time progresses, it turns out that she becomes pregnant and she hides that pregnancy in fear of being thrown out of her drug treatment site. So what we are trying to do is encourage not only random regular kind of pregnancy screening so that we can identify women earlier, but then if we can support that pregnancy and get her the care that she needs.

Chairman MILLER. Or I assume change the notion that she should then be thrown out of a program because she has become pregnant.

Ms. POTTI. Right. But that occurs now, it does occur now.

Chairman MILLER. Ms. Kenyatta, let me ask you a question. You mentioned that your clients are required to get their own transportation and you see that as a way of forcing them to learn to use the system. And yet we have heard in so many programs that transportation is in fact a barrier to sustained treatment. You do not see it that way?

Ms. KENYATTA. Well we also recognize that. But we also recognize that there are programs out there that provide free transportation and that our program at this point cannot do that. So we refer them to places like Crossroads or a program called FISH and other services that would give them bus tickets. They cannot afford it with their limited income, but they can learn how to utilize the system to get what they need.

Chairman MILLER. That is interesting.

Ms. Johnson, you and Reverend Earl really are sort of talking about rebuilding the community; on the earlier panel you heard the discussion of the chaos that many of these women live in and you testified that you live there yourself to some extent. That would be a major ounce of prevention here if in fact there was stability and a sense of community available to these individuals without the need of treatment programs. But that is really what you are embarking upon here, is it not? You are talking about economic support in terms of small businesses, you are talking about stable housing, you are talking about stable patterns of community that all of us want for our own selves. I have got to commend you I guess like everybody else because I think when we get all done with all the treatment, we are kind of back to where do you go home to. And that answer is pretty bleak certainly for the vast majority of women that had enough courage to even enroll in these treatments. So let me commend you and I would like very much to have a copy of the article.

Ms. JOHNSON. Okay.

Chairman MILLER. And also the one on Reverend Earl. I want to be sure we treat you both the same here.

Mr. Todd, let me thank you. Mr. Durbin may have more, he is Mr. Smoke Free in the Congress, but I have been discussing this for some time with the WIC programs in our area and we have not quite achieved it in terms of how they fit this again into allowable cost and how do you treat this in terms of your administrative expenditures. But obviously with the kinds of returns that you are talking about in the cessation and the reduction in smoking, we are going to be in the process of reauthorizing WIC and I think we have got to think about how we make that allowable as an integrated part of that program and I think I agree with you. The

women I have interviewed have enough trouble getting to WIC on a regular basis now—to have to come back is a deterrent, so we have got to figure out how we do this in that integrated program.

Mr. Durbin.

Mr. DURBIN. Thank you very much, Mr. Chairman.

Mr. Todd, I just want to echo what the Chairman has said very briefly. With your permission—even without your permission—I am going to take your statement and put it in the Congressional Record because I think it is important separate and apart from what we are considering today, that the members of Congress focus on this issue. I am the co-chair of the task force on tobacco and health and we are looking for opportunities of reducing the number one preventable cause of death in America.

Mr. Miller's home state of California is dedicating some tax revenues now from cigarettes to discourage smoking. And I think we need to do that on the federal level, not only to the population at large but to those at particular risk, children and mothers.

It was interesting, when our drug bill went through the first time, we included counseling in the drug bill for WIC recipients on the dangers of substance abuse. We were unsuccessful in our political efforts to include tobacco. As we can see from your statistics, they should be included.

Ms. Scott, it is good to see you again. We visited together in Chicago when you were kind enough to visit our earlier hearing. Can I ask you one specific question about the Cook County Jail situation. When it is discovered that a woman in the Cook County Jail is either drug dependent or pregnant, is there any means now for you to access court services and make some sort of counseling part of the condition of parole or probation?

Ms. SCOTT. Basically what is happening now, a lot of the systems are changing where that is beginning to kick in. The state—and I am a local provider, division of the YMCA but state funded—state administrators have met with the judicial administrators in Cook County to begin to set up those specific kinds of arrangements. Once women come through a variety of entry points, whether it is because of illegal activity related to drug use, or whether it is related to situations with the other children. If they enter the court system and it is determined that there is a drug and/or alcohol problem existing in concert with pregnancy, then the judges are being asked at this time to issue as a part of their court order a requirement that the woman seek treatment and link into the new "Drug-Free Families with a Future" case management units. So as a local provider, we are very happy to see that. We have become a little concerned because we recognize that there is a major need out at the local level and although we are happy with the resources that are coming down, we recognize that this is just the very tip of the iceberg in terms of the level of need that exists out there.

Mr. DURBIN. Thank you very much, and I want to thank the remaining members of the panel for their participation.

Thank you, Mr. Chairman.

Chairman MILLER. Mr. Holloway.

Mr. HOLLOWAY. Ms. Kenyatta, the first thing I want to ask you is how does your program differ from the Hutzel program? What is the difference basically in HUG and the Hutzel program? My un-

derstanding is that you might have originally been there and broke away. What are the major differences in the two programs?

Ms. KENYATTA. Well I think basically in that we utilize more community people. The community are very much involved in our program, as I stated in the paper, in terms of decision-making and helping the women to develop certain skills. Also I think we differ because we have a holistic doctor in the sense that she totally stays away from any form of drugs. We do recognize the need for some pregnant women to use methadone but her philosophy is totally different in that she utilizes herbs and spices to help women to create a natural balance in their life.

Mr. HOLLOWAY. What is your capacity?

Ms. KENYATTA. We have a total of 57 rooms, we can double that amount depending on the number of applicants. We currently have about 38 women and 32 children in the program.

Mr. HOLLOWAY. So do you or you do not have a waiting list?

Ms. KENYATTA. Well our program is somewhat unique in that whenever women come, our philosophy is to try to accommodate them as soon as possible. When our beds are all full, what we do is we have a big waiting room similar to a shelter type concept where we will allow women to stay there until a room is available to them. So we rarely have waiting lists. Our philosophy is to help them as soon as they ask for help, if we can.

Mr. HOLLOWAY. How are you funded?

Ms. KENYATTA. At this point, we are totally dependent upon patients or our residents' contributions and donations from the community. We are not receiving any grants, and we are really struggling.

I do want to say this though. Friday, we found out that through the Department of OSAP here, that they are going to start funding us for Medicaid, being a residential program. So I think that has a lot to do——

Mr. HOLLOWAY. That is good because that was my next question. Ms. Walker was saying there was residential funding, but will you be receiving that in the future?

Ms. KENYATTA. We had tried to apply before, but again, due to certain regulations because we did not have a contract or were not receiving funds from the Office of Substance Abuse, they said we were not eligible for the monies, but I guess something changed and they decided to make us eligible.

Mr. HOLLOWAY. I think as Ms. Johnson said, maybe the biggest problem is the difficulty of getting federal funds to the grassroots. With our terrible bureaucracy and abundance of forms, it makes it tough on the grassroots ability to participate in some federal programs. If they do not have a lawyer and an economics professor to fill out their forms they cannot get them filled out and live by them.

Do you accept young ladies into HUG, under 18?

Ms. KENYATTA. No, we do not.

Mr. HOLLOWAY. So basically the only program in town is your program, for those under 18, Ms. Potti?

Ms. POTTI. Well there are currently no programs and we have asked OSAP to expand the MISAN project. Riverview Hospital has committed to 100 adolescent substance abuse treatment positions

provided that we can get the dollars available in order to do that, so we are waiting for pennies from heaven I guess.

Mr. HOLLOWAY. We appreciate grassroots programs and I think they are the only way to solve the problem. We cannot do it. This is similar to the problem with the shortage of jail cells. We cannot spend $125,000 on every prisoner we incarcerate. We must have assistance from the outside, people willing to participate and be a part of the system.

I just want to say a word or two to Reverend Earl. It looks to me like you would be an example to the rest of the churches. If you are not going to get out and help the community and try to work in the community, what is the purpose of the church? We all believe and we want to work toward a belief in God, but there has got to be more to a church than just simply trying to convince people—do you see any churches following your lead or anything happening in the community along that line?

Reverend EARL. I think that for a long time the church has been involved in creating community. I think that if you were to talk to people like Charlene and other women that made alternatives and chose not to become a part of what was going on in that environment, most of them were very active in the church. The church has been providing that support system all along. I think that with this new drug initiative that we are facing in our community, it is bringing on some new demands and some new challenges to the church and it is requiring the church as it is all the rest of our society and every other segment of our society, including Congress, to think about some things and move into some areas that are basically uncharted. So the church is struggling to re-examine its theology, the ministers are struggling to re-examine their roles and then we have the additional burden of trying to better understand the doctrine of separation of church and state. It is a problem that is destroying the state and the church at the same time, and I do not know how we can remain separate—maybe we can remain separate in philosophy and separate in theory, but we are going to have to hold hands in terms of being out there on the street. So I think that we are just in the process of doing what we have been doing and that is providing the central support to keep whatever stability we do have in the neighborhood and to support the families that are surviving and then try to think through our theology to allow us to address that, and like someone has just mentioned, that is a process and we have bureaucracy within that church and we have political realities within the church like everyone else.

But I do think that the ministers need to be encouraged. At one point I remember being a minister, it was easy to be a conscientious objector to the war but in this war you would have to be unconscious to object to it. [Laughter.]

Mr. HOLLOWAY. I will close just by saying I would like to know from Ms. Kenyatta, what happens to your people after they leave your program? Are you able to follow them up? I guess that is my greatest concern, considering the amount of money we pour into these projects, what happens with the people after they finish the program. They have to go back in a bad environment sometimes, but—are you able to follow up and know what happens with them?

Ms. KENYATTA. We have really struggled with that, trying to find out-patient programs for women after they complete the residential program. There are not many programs that will accommodate them. So in turn what we had to do is we kept the women as a part of our program. We have recently expanded our out-patient or our residential license and hopefully it will be approved soon, so that we can do out-patient services not only to the women that go through our program but also women who complete other programs and get somewhat lost in the system.

We also through our Buddy System have been encouraging women to establish sub-groups where they are living in the same community and being real supportive of each other, and that seems to be working. Many of them have found maybe a flat and they share the flat and they support each other through the recovery process.

Mr. HOLLOWAY. I can understand that, because if an alcoholic only has alcoholic buddies, it is kind of hard to ever quit being an alcoholic. So that sounds fantastic.

Ms. POTTI. From the public health perspective, I would also like to add that we follow infants at least through age one. We are concerned with the infant mortality number which occurs at age one. So we do follow infants not only by putting professionals and paraprofessionals in the home. And the intent is to be able to follow that child to age three when we drop that child in a Head Start Program, so that we feel that we have been able to follow this family, monitor some of the parenting, hook them up and link the community resources and then to support them as they enroll in Head Start.

Mr. HOLLOWAY. Thank you. Thank you, Ms. Johnson, for your excellent testimony and all the other witnesses. We appreciate your work very much, not only the work you do through government programs, but also the work you do on your own initiative to try to get out and start something else. Thank you very much.

Chairman MILLER. Let me thank all of you. Obviously as we try to better understand these women, we also are trying to better understand what models work to help their permanent recovery if we can achieve that. And I think this morning has been very enlightening to us. The range of programs here that again help us to delineate what is necessary to try to achieve that recovery status. This has been helpful to us. I will have to say that sometimes you get the image, if you are not from Detroit, that this is sometimes a city that has given up, but I think there is a lot of suggestion here that it is just the opposite, that there is quite a bit going on here. Certainly not enough yet to match the magnitude of the problem, but certainly something that you can take some pride in, in terms of getting a handle on it. You are probably further ahead than most communities in terms of what we have been listening to.

So thank you very much for your time and your effort.

With that, the committee will stand adjourned.

[Whereupon, at 12:45 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA AND RANKING REPUBLICAN MEMBER

Today, the Committee continues its series of hearings examining one of the most tragic and difficult social problems of our day: substance-abusing mothers, and by extension, the plight of their children. Today we are taking an important step by addressing how these women can find help to extricate themselves from enslavement to street drugs.

Our hearing's title emphasizes barriers to treatment. But it is my hope that Members will remember the success stories, the programs and initiatives that work. As with other programs that seek to deal with social or individual needs, the barriers tend to be the same, and we are already familiar with them. We know, for instance, that programs created by Washington for imposition on states and localities usually cannot help but lack flexibility. Unfortunately, in its well-meaning attempts to help, government often erects the strongest barriers to access through rigid policies, an excess of categorical-style programs, poor coordination with other programs, and an inability to channel financial resources in ways that states and localities can use most effectively.

In that regard, several witnesses make important points. Director William Atkins of the Illinois Department of Alcoholism and Substance Abuse notes that his state's most promising rehabilitation program stresses community-based, family-centered, flexible approaches with a continuum of care. Maisha Kenyatta of Detroit's HUG, Inc., observes that her program provides a wide spectrum of therapeutic services, with the family's as well as the addict's needs in mind, to promote drug-free living. Her approach works because it is local, flexible, and not hamstrung with requirements imposed by far-off governments. And Mrs. Charlene Johnson, representing the very successful REACH, Inc., program, states that her community-based approach, stressing holistic treatment, relies upon local people and institutions to solve local problems. Of all the financial support REACH receives, Federal aid is the most difficult to obtain and most complicated to use, she indicates.

If we are to realize widespread success in the war on drugs and substance abuse, we need to learn the lessons about what actually produces results. To me, it seems clear from what our witnesses are saying today that these components are vital: a community-based, even neighborhood-based approach works best; addressing the needs of children and families of substance-abusing women is crucial because their recoveries, like their conditions, do not develop independently; government aid must be provided under the least intrusive and restrictive conditions possible so that programs can adapt to local needs; helping the addicted woman with training, discipline, education, life skills and techniques for re-entry into the community as part of a treatment program are as important as direct treatment.

As we look at the problems faced by substance-abusing women, we should keep in mind several points. First, when there are children involved, they also have rights, and a balance must be struck between these rights. An unborn child deserves to enter this world drug-free, if at all possible. This means that we must develop intervention strategies to help the addicted mother for her own sake as well as that of her child.

Secondly, we should be prepared to make necessary choices when treatment fails. That is to say, adoption must be highlighted as an option for children when a substance-abusing mother is unable or unwilling to respond to counseling and treatment. Even as an addicted mother may suffer, a child's suffering as a result should not be compounded through failure to correctly perceive what that child's long-term best interests are.

Let us come away from this hearing with a better understanding of what truly works here on the front lines. Let us learn more about why some people obtain treatment while others do not. And let us come away prepared to make adjustments in order that the substantial investment we already have in substance abuse treatment pays real dividends.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515

GETTING STRAIGHT: OVERCOMING TREATMENT BARRIERS FOR ADDICTED WOMEN AND THEIR CHILDREN

Minority Fact Sheet

April 23, 1990

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Prepared by Cathy Deeds and D. Jeffrey Hollingsworth

FACTS AND FINDINGS

WOMEN AND DRUG USE

o Best estimates based on the National Drug and Alcoholism Treatment Unit Survey (NDATUS) and national prevalence data indicate that 1 out of 3 alcoholic or alcohol abusing persons in the U.S. is a woman, and 1 of 20 of these women is in treatment in a given year. Of the other drug users, 2 of 5 is a woman and 1 of 50 of these is in treatment in a given year.
(Ruth C. Engs, R.N., Ed.D., Editor, Women, Alcohol and Other Drugs. Kendall/Hunt Co.: 1990. page 10)

COST OF DRUG TREATMENT

o According to the Treatment Outcome Prospective Study (TOPS), the average lengths of stay are 159 days for residential treatment, 267 days for outpatient methadone treatment and 1001 days for outpatient drug-free treatment. These lengths of stay result in total average treatment costs for a single treatment episode of $2,942 for residential, $1,602 for outpatient methadone and $606 for outpatient drug-free clients.
(Alcoholism and Drug Abuse Week, Oct. 25, 1989, pp. 6-7)

LITTLE KNOWN ON WOMEN AND COCAINE TREATMENT

o "A legal substitute for cocaine is not available and those who treat women cocaine addicts find the addiction extremely frustrating. At present the female addicted to cocaine is a primary challenge to the field of public health because of the risk of contracting and spreading AIDS and the refractory nature of the illness."
(op. cit., Engs, page 12)

o "The widespread inexpensive availability of cocaine is a new phenomenon. Treatment programs have not faced this kind of cocaine dependence before and thus we have no backlog of experience and data to draw from." ("Drug Abuse Treatment," National Institute on Drug Abuse (NIDA) Capsules, June 1988, page 4)

SPECIAL NEEDS OF PREGNANT WOMEN

o "Pregnant addicts are often among the most reluctant to seek treatment, and many treatment programs are not equipped to accept them. Pregnant addicts in the custody of the criminal justice system can sometimes be required to remain in residential treatment until after they deliver. But outreach efforts are needed for other pregnant addicts, who must willingly enter and remain in treatment programs providing pre-natal and post-partum care for them and their children."
(Statement of Dr. Herbert D. Kleber, Deputy Director for Demand Reduction, Office of National Drug Control Policy, Before the Senate Subcommittee on Children, Family, Drugs, and Alcoholism. March 8, 1990)

o "The use of pharmacological interventions in the pregnant woman have to be evaluated with even more caution, not only because of the the quick dependence (30 to 60 days) but also because of potential effect on the fetus."

(Statement of Dr. Raul E. Cuervo-Rubio, M.D., Chief Medical Advisor for the Office of Substance Abuse Prevention, to the Physicians Curriculum. By National Association for Perinatal Addiction Research and Education. Jan. 31, 1990)

TREATMENT EFFECTIVENESS

o "It is not known what treatment regimes work best for women or whether specialized treatment programs are more effective than traditional programming. Consensus of those working in the field is that to be clinically relevant programming must acknowledge that: drug use patterns change with age; sensitivity to differences in ethnicity and sexual orientation is imperative if treatment is to be relevant; many women in treatment will have been victims of physical and sexual abuse at some time in their life; many of them will have eating disorders; a significant number of them will be diagnosed as suffering from anxiety and depression; and many of them will be dually addicted." (Op. cit. Enga, page 11)

o Studies evaluating the effectiveness of treatment modalities confirm that a high percentage of individuals show significantly improved behaviors consequent to leaving treatment. The behavioral criteria used to evaluate treatment effectiveness looks at: diminution in drug use, diminution in criminal activity and increased productive activity. (Ibid., page 2)

RELAPSE

o "Whether a patient is in or out of treatment, or beginning or ending treatment, relapse remains a high-probability event. This highlights the lifelong challenge of maintaining abstinence."

(Barbara Wallace, Ph.D., "Psychological and Environmental Determinants of Relapse in Crack Cocaine Smokers," Journal of Substance Abuse Treatment. Vol. 6, 1989, p. 96)

BUDGET HISTORY OF STATE SUBSTANCE ABUSE PROGRAMS

o Outlays by states and territories for "drug abuse and alcohol services" (treatment and prevention) using funds from all sources (i.e., state budgets, Federal grants, county and local monies, etc.) increased 55.1% from FY 1985 ($1.36 billion) to FY 1988 ($2.11 billion). "Overall expenditures by types of Program Activity...reflect a significant growth in expenditures for treatment and prevention."

(State Resources and Services Related to Alcohol and Drug Abuse Problems, Fiscal Year 1988, National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), Washington, D.C., pp. 1, 11-12)

- State-generated revenue spent for alcohol and drug abuse services by state alcohol and drug agencies increased by 39% from FY 1985 ($654,430,812) to FY 1988 ($909,875,851). Support provided by "other state agencies" (i.e., divisions other than the alcohol/drug abuse agency) was up 88.9% in the same period, from $58,916,203 in FY 1985 to $111,294,111 for FY 1988. These two sources account for 48% of all state-administered alcohol and drug abuse services expenditures. (Ibid., pp. v, 11, 13)

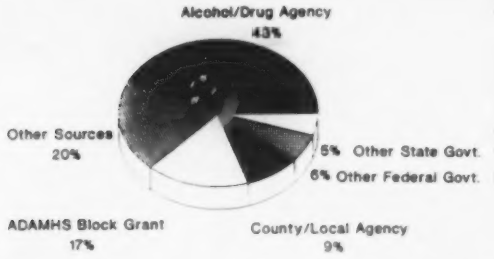
- "The total amount of funding for treatment services for women was over $349 million (in FY 1989), almost 20% of the total funding for all treatment services." ("Survey on State Alcohol and Drug Agency Use of FY 1989 Federal and State Funds," Washington, D.C.: National Association of State Alcohol and Drug Abuse Directors, (NASADAD), page 2 (highlights) and Table 2)

FUNDING SOURCES FOR STATE-ADMINISTERED PROGRAMS

- Most of the federal money for drug treatment is allocated by the Department of Health and Human Services (HHS) in the form of block grants to the States. Administered by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), the FY 1990 block grant program provides State drug abuse agencies $477 million in funding support. "For Fiscal Year 1991, the Administration is seeking to increase block grant funding for drug treatment programs by $100 million, bringing the total funding to nearly $577 million."
(National Drug Control Strategy, The White House, January 1990, page 30)

- "Title I of P.L.99-457 [Education of the Handicapped Act Amendments] creates a new Part H...authorizing Federal formula grants to States...to provide early intervention services for handicapped infants and toddlers and their families. (Those) who would be eligible for services...might include, for example, low birth weight babies, or babies with parents...who abuse drugs..." Federal funds for the first four years of this five-year program are: $50 million (FY 1987), $67 million (FY 1988), $69.8 million (FY 1989) and $79.5 million (FY 1990). (Charlotte Jones Frase, Summary of the Education of the Handicapped Act Amendments of 1986, P.L.99-457, pp. 1,3. Washington, D.C.: Congressional Research Service; Consortium of Family Organizations seminar background paper, 3/16/90: "Implementation of P.L.99-457: Parent/Professional Partnership in Early Intervention," page 11)

State Substance Abuse Funding Sources
FY 1988



Source: NASADAD report, pp. iv, v

Chart 1

o State, county and local governments generated 57% of the funds spent on state-supported alcohol and drug abuse services (FY 1988 data). The ADAMHS Block Grant provided 17% of the funds, or $355.0 million, other Federal sources contributed 6%, and 20% came from other sources, such as private insurance, court fines, and client fees (see Chart 1, above). (NASADAD FY 1988 report, op. cit., pp. iv, v)

How States Spend Substance Abuse Funds

Source: NASADAD Report, pp. iv, v, viii

Chart 2

o The states and territories reported spending $2,114,857,286 to deal with alcohol and drug abuse ("total alcohol and drug expenditures") in FY 1988. The funds were apportioned as follows: treatment, 77%; prevention, 15%, other (research, training, administration, etc.), 8% (see Chart 2, above). (Ibid., pp. iv, v, vii).

o Of the total amount spent for alcohol and drug abuse treatment and prevention services, Federal government sources account for less than one-quarter of the funds (23%). States themselves provide 48%; counties and localities contribute another 9%. Miscellaneous sources, such as private health insurance, payments by clients, court-imposed fines, etc., produce 20% of the funds spent for these purposes. (op. cit., NASADAD FY 1988, page 1)

WHERE THE FUNDS GO

o As of FY 1988, 6,926 alcohol and/or drug treatment units received funds through state substance abuse agencies, of which 1,806 (26.1%) were alcohol units, 1,614 (23.3%) drug units, and the rest (50.6%) providing combined treatment services. (Ibid., page 15)

o The states and territories report that females constitute 32.5% of the clientele for drug treatment and 21.4% of those admitted to alcohol treatment (FY 1988 data), 68% of the women admitted for alcohol treatment and 71% of the women admitted for drug abuse treatment are between the ages of 18 and 44. (Ibid., pp.22-25, 31-34)

PREPARED STATEMENT OF DON SEATON, ASSISTANT DIRECTOR OF LEGISLATIVE AFFAIRS, AMERICAN CIVIL LIBERTIES UNION OF MICHIGAN, ON BEHALF OF THE AMERICAN CIVIL LIBERTIES UNION OF MICHIGAN, DETROIT, MI

Mr. Chairman, members of the subcommittee, we appreciate the opportunity to present the views of the American Civil Liberties Union of Michigan on the question of overcoming treatment barriers for addicted women and their children.

There has been heightened concern over the often tragic effects of substance abuse on infants and young children. The response of some in the law enforcement community has been to impose criminal punishment on women for behavior during pregnancy and to call for mandatory drug screening of newborn children and mandatory removal of parental rights if a positive test is obtained. Our testimony will focus on the legal and public health effects of such policies as it relates to women seeking treatment for addiction.

In 1988 Kimberly Hardy discovered she was pregnant with her third child. Ms. Hardy knew she had a drug problem and wanted to overcome her drug addiction. Therefore she left Muskegon, Michigan to stay with her mother in Mississippi. After spending four drug-free months in Mississippi, she returned to Muskegon. However, Ms. Hardy got involved with the wrong people and started using cocaine again.

On August 20, 1989, Kimberly entered Muskegon General Hospital in the early stages of labor. Upon admission she signed a form which provided that she consent to routine diagnostic procedures and hospital care by Muskegon General Hospital, as is deemed necessary. The form did not authorize the taking of a drug test on either herself or her newborn nor did it authorize release of the test results to social service workers or to the

police.

Shortly before delivering a baby boy, at least one drug test upon Ms. Hardy for purposes of medical treatment was ordered by a doctor who claims to have such a policy in high-risk pregnancies. No consent for this or any other drug screen on Ms. Hardy or the baby was given. However, the baby soon displayed an eating disorder that upon the taking of x-rays was found to be due to a decrease in intestinal motility. Two days after the birth, the test for injection having been negative, the attending physician ordered a urine drug screen on the baby to determine the source of the problem.

On August 25, 1989 the urine drug screen indicated a positive result for traces of cocaine. On August 29, a social service worker received a call from a nurse at Muskegon General indicating that the test of the newborn's urine was positive. The Social Service worker called a detective believing that the positive toxicology was evidence of child abuse.

On September 22, the detective and the social service worker went to Ms. Hardy's home where the detective read Ms. Hardy's miranda rights and obtained an admission that she had used cocaine during her pregnancy. After returning from drug treatment which she successfully completed on November 13, Ms. Hardy was arrested and charged with second degree child abuse and delivery of a controlled substance. While the child abuse charges were dropped, Ms. Hardy still faces charges that she delivered cocaine to her baby through the umbilical cord.

What Ms. Hardy needs is treatment, not punishment. If we continue to punish women like Ms. Hardy, we will drive away those who desperately need treatment. Treatment is the key to conquer the substance abuse problem.

Dr. Sidney H. Schnoll and Dr. Lou Karan of the Medical College of Virginia Hospitals recently noted in a letter to the Journal of the American Medical Association that use of tests without proper caution will drive women away from health care:

> The issue of collecting urine toxicology test results on all pregnant women must be looked at the context in which the test is performed. We agree that mandatory drug testing of all pregnant women to punish those with positive urine drug tests and separate them from their children may have deleterious effects for mother, child and society alike. The most deleterious effect would be to discourage pregnant addicted women from seeking treatment....
>
> At present it is extremely difficult to get pregnant addicts into the few programs that are designed to provide both obstetric care for high risk patients and treatment for addiction. Using medical information such as a urine toxicology test result as the sole criterion to determine the suitablity of the woman as a mother or to bring criminal charges only compounds the serious problems they already face and discourage them from seeking pre-natal care and addiction treatment.
>
> As physicians, we must decide whether medical tests like urine toxicology screens should be used for political purposes or remain part of a comprehensive health care delivery system. We feel strongly that the subversion of medical tests for other than medical purposes directly related to the clinical case of the patient destroys the value of the test and compromises the role of the physician.

Journal of the American Medical Association, November 3, 1989, Vol. 262, No. 17.

This country has declared a war on drugs, but punitive sanctions against pregnant addicts does not address the problem. The objective of Prosecuting Attorneys' across the country is to

deter women from using drugs. But we must not deter women from seeking medical assistance for fear of criminal prosecution. This country is in need of more treatment programs for addicted mothers, but some prosecutors have decided to put emphasis punishing drug users rather than treating them.

It is the principle purpose of my remarks to emphasize that without sufficient protection of personal privacy, there is serious risk that women will come to view hospitals as surrogate police precincts and not fully disclose information that would be in their own or their children's best interests. The threat of criminal prosecution will not stop pregnant women from abusing drugs, whether cocaine, alcohol or other substances that endanger the health of the woman and the health and life of the child she is carrying. The health of both the pregnant women and the child she is carrying will be protected by expanded drug education and treatment programs.

PREPARED STATEMENT OF AMANDA L. GOOD, M.S.W. A.C.S.W., EXECUTIVE DIRECTOR, ALTERNATIVES FOR GIRLS, DETROIT, MI

Alternatives for Girls
1950 Trumbull Detroit, MI 48216 • (313) 496-0938

TO: The Honorable George Miller, Chair
Select Committee on Children, Youth, and Families
House of Representatives
United States Congress

FROM: Amanda L. Good, M.S.W., A.C.S.W.
Executive Director
Alternatives For Girls

DATE: April 23, 1990

RE: Special Needs of Substance-Abusing Pregnant, and At-Risk Teenage Girls/Young Women, and Recommendations for Effective Programming.

Mr. Chair and members of the committee, thank you for giving me the opportunity to speak on behalf of thousands of homeless teenage girls in Detroit, and hundreds of thousands in the U.S., who are desperately in need of services that are currently in short supply or non-existent, in order to, in many cases, survive their teens, and to hope for better choices for their children.

To serve young women and girls in Detroit, Alternatives For Girls (AFG) has initiated four programs in the southwest Detroit community: St. Peter's Inn, a shelter which offers both short-term stopovers and longer-term structured six-month stays; an Aftercare/General Outreach program which offers support services to ex-residents of St. Peter's Inn; a Street Outreach program which deals directly with young women already living on the streets, offering them referrals, crisis intervention, food and clothing; and a Neighborhood Prevention group program which serves to provide adult support and positive role modeling for

Dedicated to assisting young women and girls in Southwest Detroit

girls (ages 5 - 17) in the community.

While we have not conducted a scientific survey in the process of formulating a profile of the typical girl/young woman who is seeking our services, our findings from the 800 served over the past year point to a clear pattern. Of the 154 teenagers housed in our shelter, 28% have been pregnant. Approximately 72% of our residents have been alcohol/substance abusers; 25% of these being heavy and chronic abusers. As nearly 100% of our residents are sexually active, this population - homeless teenage girls - is clearly at great risk for becoming substance-abusing pregnant teens and mothers, if they are not already.

The teenagers we serve are generally invisible to the mainstream of society, who tend to have great difficulty accepting the very painful reality of thousands of girls in Detroit - hundreds of thousands in cities throughout the United States - without families, for whom a tenuous survival on the street is their best option. They are also, in most cases, "invisible" - unrecorded and unaccounted for - within our traditional social service delivery systems. Most of them have never been on public or private social service or child protection caseloads; many have long been "missing" - there is no one looking for them any longer. It is only through our pro-active, on-the-street outreach that we are able to first connect with many of them, and to begin to "spread the word" about our services that reaches multitudes more.

We have learned in the two years that we have provided

shelter, crisis intervention, and support services that teens seeking shelter in Detroit are, in large part, homeless as a result of disintegration of their families. Close to 100% of our shelter residents have been victims of childhood sexual abuse. They have grown up in environments fraught with substance abuse as well as drug dealing, school dropout, transient living and homelessness, early pregnancy, and prostitution; both in their homes and in their immediate neighborhoods.

Given the vicious cycles that perpetuate homelessness and high-risk behavior among teenage girls, and the profound barriers to be surmounted in attempts to kick a drug habit, exit familiar street life and all of the tried and true coping mechanisms associated with it, the gaps in critical services needed by this population are alarming:

1. There is not a single residential treatment space available for a substance-abusing, pregnant, and poor teenager in the city of Detroit. We must, as a result, "do somersaults" to find makeshift plans for the young girls that approach us on the street and announce their readiness to go into detoxification and treatment -today. Sadly, they may not be ready for detoxification in three weeks when a space becomes available, and they may be unable to continue their struggle at all without a residential treatment program to follow detox that is unquestionably therapeutically indicated by substance abuse experts.

2. Very few of the girls/young women on the streets have accessed any sort of health care since they became homeless, including pre-natal care, often throughout an entire pregnancy. Multiple factors contribute to the high level of risk that these girls/young women face, to their own health, to unborn children, and to the community.

3. Active street outreach is the only way to

reach, offer services to, and advocate for many of these teens. There are several effective models throughout the country that can be duplicated and revised to meet the unique and specific needs of any U.S. city.

4. Homelessness itself, in our observations, is highly correlated with substance abuse and high risk sexual activity that leads not only to pregnancy but to sexually transmitted diseases including AIDS. As an example, the Detroit/Wayne County Homeless Strategy Coalition conducted a study in 1989 that revealed that the Detroit shelter hotline receives over 2,500 calls per month, of which "only 45% are able to be placed in shelter. Those who have most difficulty being placed are runaway or homeless youth, pregnant teens, and persons with mental retardation, mental illness, or other serious illness. "Forced to fend for themselves, homeless teens have few alternatives to bartering their bodies and services in the drug trade - which often includes their entrapment by dealers through their own addictions - for shelter, food, and clothing. Alternatives For Girls is the only shelter for homeless teens in Detroit, we are able to take in about half of those who come to us seeking shelter.

5. Finally, our very simple and cost-effective Neighborhood Prevention Group Program is showing signs of outstanding success in keeping children in school, raising their self-esteem, and giving them tools and support with which to seek and make positive choices for themselves. We serve 145, high risk, but not currently homeless, girls ages 5 to 17. We are, unfortunately, unique in our city offering this type of active outreach in the hearts of the afflicted neighborhoods. Prevention programs are difficult to fund, especially at the federal level, and so are few and far between, but may well be the most effective use of our money. Simply put, building self-esteem along with school retention can be the key to prevention of many problems, including substance abuse, early pregnancy, school drop out, prostitution, and homelessness.

I would hereby offer the following recommendations:

1. Highest Priority - Residential treatment for low-income substance-abusing, pregnant teens in Detroit, and in cities where it does not already exist.

2. Provide funding for accessible health care for homeless teens as well as adults.

3. Provide for direct, on-the-street outreach programs aimed at homeless teens in all major cities. Left unaided and remaining "invisible," these teens are obvious potential victims of pimps, drug dealers, and perils of street survival that includes AIDS, other STD's, high-risk pregnancy, violence, chronic homelessness, and the continuation of these conditions into young adulthood, parenthood, and onto the next generation.

4. More federal money needs to be available for existing transitional housing programs, and not merely for new projects or expansions. While new programs are necessary, existing programs could better service clients if the stress of funding were alleviated and more general operating funds were available.

5. Prevention programs for younger aged youth similar to ours need to be developed and provided with adequate funding. We have had measurable improvements in self-esteem and motivation and, thereby, increase in school attendance and achievement among our group participants.

Thank you for your concern and attention to the little-known plight of drug-abusing pregnant women, and especially, the even lesser-know plight of drug-abusing, pregnant, and high risk teens. The solutions do not, in my estimation, lie in yet-to-be discovered "technology" of treatment. They lie in a coordinated effort at all levels, from the federal level to the neighborhood levels, to share information about programs that exist and that work, to amend them to suit each community in need, and to prioritize our resources in ways that will indeed, support life.

Prepared Statement of Raj M Wiener, State Health Director, Michigan Department of Public Health, Lansing, MI

Thank you for this opportunity to provide testimony to the committee. I want to commend the committee for examining perinatal substance abuse from the perspective of treatment barriers. We must emphasize prevention, education and treatment as the answer to the complex drug problem, as opposed to the growing emphasis on the criminal justice system.

The Michigan Department of Public Health has worked closely with the Office of Substance Abuse Services and the Department of Social Services to identity the barriers to an effective strategy for reducing the impact of substance abuse on maternal and infant health. The strategy includes efforts to improve intervention and treatment and to better and more completely understand the extent and nature of drug use in pregnancy. This committee made a substantial contribution to our knowledge of the damage to women and babies resulting from substance abuse during pregnancy through the hospital survey conducted in 1989. Because of this examination and others, you are familiar with the immensity of the problem: Using NAPARE's finding of 11% of deliveries affected by substance abuse, we estimate that 15,000 Michigan infants were affected by substance abuse during pregnancy in 1988. The state's infant mortality rate for 1989 is expected to be higher than 1988, and the impact of substance abuse is seen as a key contributor to the increase.

The barriers to treatment for substance using women and their children exist in four principal areas:

1. **Lack of Capacity** - The most fundamental barrier is the lack of any treatment for drug using pregnant women. Specialized services for women have not been a priority.

In Michigan, only 10% of residential treatment programs can be identified for women, in general. Now we are faced with the challenge of developing treatment programs which recognize the need for intense and comprehensive intervention aimed at families, and not just individuals. We are fortunate to have the Eleonore Hutzel Recovery Center providing comprehensive services tailored to the needs of mothers. However, one program in the state can not meet the need.

2. **Complexity and Intransigence of the Problem** - The historical focus of the treatment system on male addiction does not prepare us for the challenge of maternal substance abuse. We must emphasize the design of treatment goals, objectives and methods that are relevant to the needs of women. Specialization for women must extend current models of addiction and treatment to reshape existing programs. Dr. Poland's survey of pregnant women in Detroit demonstrated that pregnancy prompted many women to reduce or discontinue the use of cigarettes, alcohol and illicit drugs. This indicates women are motivated during pregnancy to address chemical dependency, given the accessibility of suitable programs.

3. **Punitive Response** - Over half of the state legislatures have taken up the issue of maternal substance abuse, considering laws which would require physicians to report pregnant women who use drugs or amending child abuse laws to require reporting of exposed newborns and allowing for the prosecution of the mother. The use of criminal sanctions as a vehicle for reducing substance abuse during pregnancy will in fact lead to more women avoiding the care they need. Delayed prenatal care likely to be the result, with its negative health consequences for both mothers and infants. Mandatory referrals to child protective services is equally inappropriate. Child protective services should only be used if the child's well-being is in jeopardy or if other preventive services have failed. An arbitrary and automatic investigation by child protection will reduce the effectiveness of early intervention and will drive families away from service.

4. **Lack of Comprehensive and Relevant Programs** - We have identified the lack of substance abuse treatment for pregnant women. Given the insufficiencies of the current treatment system and the urgency of the problem, more must be done to redirect current programs and integrate them with other necessary services. Coordination of a core of minimum services which can be made available to women, tailored to their individual needs, is essential. Fundamental to the core of services is the linkage of substance abuse prevention and treatment and prenatal care. Such linkages must be supported by the education of prenatal care and substance abuse treatment providers in the recognition of substance abuse in pregnancy and in the most effective outreach and case management approaches for pregnant substance abusers.

The Michigan Department of Public Health, in cooperation with other state agencies such as the Office of Substance Abuse Services and the Michigan Department of Social Services, has taken the following steps to remove barriers to treatment:

1. Established model programs for the integration of prenatal care and substance abuse treatment and the strengthening of supportive services. The fiscal year 1990 state budget earmarked funds to support programs for chemically dependent pregnant women. In response to a request for proposals, several communities submitted model program demonstrations to provide integrated prenatal care and substance abuse treatment. Unfortunately, funding is sufficient to begin only a very limited number of programs. The model programs which will be implemented have demonstrated interagency coordination between substance abuse treatment providers, hospitals, and local health departments. Each will provide a minimum core of essential services which includes outreach, case management, integration of prenatal care and substance abuse treatment, and supportive services such as child care.

2. Proposed a mechanism, the State Maternal Substance Abuse Interagency Committee, to develop policy regarding identification of chemical dependency in pregnancy, confidentiality, drug testing, eligibility and reimbursement for programs, and to disseminate the information gained from the model program demonstrations.

3. Developed the Sentinel System, which is a program of infant support services with a goal of maintaining high risk infants in an optimal, nurturing environment. Infant support services includes nursing, social work, nutrition and infant mental health services, to assure that babies get regular health care and parents get needed services such as substance abuse treatment, education about infant development, and help with child care. The target clientele includes infants born with exposure to alcohol abuse and/or illegal drugs. Central to the Sentinel System are formal interagency agreements detailing each agency's responsibility and authority, release and confidentiality of client information, and identifying a coordinator from each agency involved with a family. The Sentinel System is a preventive intervention which should be the first response to parental substance abuse and newborn exposure to drugs, as opposed to automatic child protective services investigations.

The model programs which will be implemented in Michigan will link the two systems most central to the reduction of maternal substance abuse: prenatal care and substance abuse treatment. While these models will provide the opportunity to link substance abuse treatment with special programs which the state has devised to increase the early and continuous use of prenatal care, such as paraprofessional outreach and maternal advocates, much support is needed to enhance the services which are the underpinning, including:

- Attention must be given to the basic problem of prenatal care access for all women, the paucity of substance abuse treatment for women, and the lack of responsiveness to the unique needs of women with chemical dependencies.

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- Other services must be maximized to provide the health and supportive services needed by mothers and infants exposed to substance abuse, such as the Sentinel System and EPSDT. Federal leadership is needed to encourage flexibility in policies supportive of the use of these resources.

- Funding for the Maternal and Child Health Block Grant should be increased so that maternal and child health services can address the need for preventive and supportive services.

- Public awareness of the problem of substance abuse in pregnancy must be increased and preventive education must be intensified. Many still believe that the recreational use of cocaine is harmless.

- Support is needed for training of health care workers to recognize substance abuse and to offer nonjudgmental and nonthreatening assistance to women in confronting their drug problem and understanding the dangers of drug use during pregnancy.

Again, I thank you for focusing on the most effective strategy for reducing maternal substance abuse: the elimination of barriers to treatment.

PREPARED STATEMENT OF MARCIA DECANN ANDERSEN, PH.D., RN, FAAN, CS
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Good morning! It is an honor indeed for me to have this opportunity to address this Committee. Thank you for inviting me to provide this testimony.

My name is Marcia Andersen, and I am the President of Personalized Nursing Corporation, P.C. which conducts the country's most important nursing outreach project for AIDS prevention among hard-to-reach, active IV drug users who self-present in hospital emergency rooms in the states of New York, Michigan, and Maryland. I also am an adjunct associate professor of nursing at the University of Michigan School of Nursing and also at Wayne State University College of Nursing. Both in my academic career and in my government-funded projects, I have specialized in improving the well-being of hard-to-reach populations, such as drug addicts and the mentally ill.

As Project Director of a multi-state, AIDS prevention nursing outreach project funded by the National Institute on Drug Abuse to hard-to-reach IV drug users--which has succeeded in significantly reducing frequency of heroin and cocaine use in this population--I have gained considerable experience with the lifestyles, attitudes, belief-systems, and needs of America's drug addicted. Moreover, I have recently formulated a special program design to provide residential aftercare for recovering drug-addicted persons. And so I am honored to share my experience, and my ideas for sensible and humane program initiatives, with this Committee.

I will begin by describing briefly the special need in Detroit for effective aftercare to assist drug-addicted persons to re-assimilate into the community and to maintain drug-free lifestyles. I'll then briefly describe the theoretical basis for the aftercare design I have fashioned, and follow by describing what I and my colleagues call the LIGHTHOUSE/Lodge Program of aftercare for formerly drug-addicted persons immediately up their emergence from drug detoxification programs.

BACKGROUND AND SIGNIFICANCE

It is estimated that Detroit has 35,000 to 40,000 IV drug users.[1] The Drug Abuse Warning Network's (DAWN) survey of 37 of the 49 eligible emergency rooms in Detroit reports that Detroit had the second highest (after NYC) numbers of mentions of IV drug use in the nation in 1987.[2] According to the DAWN report, Detroit had 4,522 intravenous drug mentions. In Detroit, the Michigan Department of Public Health has noted an alarming trend. IVDU-associated HIV cases are increasing at a greater rate than HIV cases due to other known means of transmission.[3] With the accelerating rate of HIV infection developing in IV drug users, their sexual partners, and their children, it is critical to develop programs to facilitate drug-free functioning in the community after treatment.[4] Programs like the Delancy Street[5] Program in San Francisco[4] and the Lodge Society[5] have demonstrated such programs can be very successful and are greatly needed.

The critical importance of social network support for recovering IVDUs in their post-treatment phase has increasingly been recognized.[6] Social support aftercare is essential as an aide to clients in making use of their newly-acquired coping skills in adapting to their community, as well as an aide assisting them to assume the unfamiliar roles of stable employment, of responsible family membership, and of personal development.[7] While the primary psychological goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use, a key social goal also must be achieved by IVDUs in the post-treatment phase: development of a responsible drug-free lifestyle. Stable recovery depends upon a successful integration of both these psychological and social goals.[8]

For example, family support has been shown to be a strong predictor of post-treatment success for recovering IVDUs.[9, 10-12] Peer factors, likewise, have been established as significant post-treatment correlates of relapse for recovering IVDUs, especially the influence of key friends and associates.[9] Krohn[13] found that those who relapsed were more likely to have best friends and friends with whom they associated most often who were current drug users, as compared with a group of non-relapsing former IVDUs, who lacked such drug-using key friends and associates. Similarly, social isolation or social alienation following treatment has been found to be a relapse correlate by some researchers.[14] Moreover, a lack of client involvement in self-improvement activity in the post-treatment phase has been found to be associated with drug relapse[15]. In contrast, those who find rewarding employment or who enroll in enjoyable schooling are at much lower risk of returning to substance abuse.[15-17]

Theoretical Basis For Experimental Treatment Fairweather's Lodge Society: The Project's Group Living And Working Model

All of the above-mentioned post-treatment correlates of drug-abuse relapse are parallel with the correlates underlying the Fairweather Lodge Society model of social support shown to be

effective for recovering mentally-ill patients.[5,18,19,20] The Fairweather Lodge Society model postulates that a critical goal of post-treatment interventions must be the assisting of the client to regain full, participatory involvement, or "citizenship," in his social community. Individual participation in all of the social processes of the client's reference social group greatly enhances post-treatment success, Fairweather found. Such client functioning, moreover, can best be achieved by social participation in which the client has a personal stake in the outcome of the social enterprise. This leads to client self-enhancement, an improved client self-concept, particularly where there is a recognized social role for each participating person in the reference group. Each client's social role in the group must reflect the highest level of personal functioning possible for the individual at the time. "Enhancement of the client's self-concept while belonging to the group, moreover, will provide a support system for the recovering individual regardless of what his/her problem is (alcoholism, drug addiction, or mental illness)."[5, p. 90]

Because "[o]wnership is an important aspect of being a first-class citizen in capitalistic American society, people who do not own anything are typically those who are outcasts from this society."[5, p. 90] Accordingly, the Fairweather Lodge model of social support has as a central feature the group ownership, group self-management, and group operation of a non-profit business enterprise chosen by, and well-suited for, the particular group of individuals constituting the Lodge Society. Fairweather has shown a substantial reduction in mental illness recidivism when Lodge members were permitted to own and operate their own janitorial service or similar business enterprise, combined with genuine freedom to participate in the decision-making of the business.[5]

Fairweather's pioneering work developed the good living and working setting where the strengths and weaknesses of former mental patients were balanced by their working as a team.[5] He demonstrated that new and meaningful social statuses and roles could be created in the community, so these persons could participate more actively in the social processes afforded ordinary citizens. He noted that his program combines the three areas stressed in other aftercare programs, which usually only stress one area per program. The areas are: interpersonal processes and socialization; employment in the community; and housing and living arrangements. His experimental group ($N = 75$) did stay in the community longer (reduced recidivism) ($p < .05$) and did gain and retain employment more effectively than his control group ($N = 75$). He states the key is in building a new social institution which creates a new network of social relationships that represent a more participative status (i.e. dope addict or patient vs lodge executive committee member or lodge cooking crew chief or member). He developed 17 operating principals for community treatment, 13 articles governing policy of lodge membership, and executive committee rules of organization. His goal of rehabilitation is the "maximization of a person's participation in the larger society to the extent possible at a particular time, without punishing those not currently capable of it."[5, p. 336]

He feels, "For too long the concept of illness and cure has restricted the imagination of those charged with the responsibility of aiding patients."[3, p. 17] He recommends creating a particular social system to alleviate the deficits of populations of people. The Fairweather program was a business (running a lawn/gardening and janitorial service) first and a rehabilitation program second. Ego involvement of participants and creation of a new status for them (business owner) was found to be essential to have success in reducing recidivism. The tasks the members perform in the lodge must be meaningful to them. Fairweather noted that throughout the course of the experiment, lodge members thought their work was important and became increasingly proud of their organization. They wanted the organization to succeed, and members often remarked how proud they were of their business. This feeling was enhanced by ownership of the business. "Such ownership is important in our culture where much value is placed on ownership of property. Ownership leads to a feeling of personal worth."[3] Over the years, Fairweather solved all the problems and thorny questions that arose and published manuals and developed training programs for project staff. He has agreed to serve as a consultant on our project and is excited to try his Lodge Society with drug users.

LIGHT Model - The Project's Individual Case Management Model

Andersen's Personalized Nursing LIGHT Model will be the model used in individual case management counseling sessions in this study. This combined individual/group approach will enhance both the Fairweather "group-only" approach and the LIGHT Model's "individual-only" approach. Drug users have responded favorably to nurses skilled in bonding with them. The connection is helpful to both the nurse and client as they learn from each other enhancing follow-up for case management counseling sessions.

The LIGHT Model is a model for nursing practice derived from a synthesis of Aristotle's theory of ethics[21] and Martha E. Rogers' science of unitary human beings.[22-27] The LIGHT Model provides a mechanism for nurses to assist clients to improve their sense of well-being. Andersen believes that improving the client's sense of well-being is the focus of nursing. Using principles synthesized from Aristotle and Rogers, clients are encouraged to use their talents in the pursuit of excellence and to take action themselves to remedy client-identified focal concerns. Clients' perceived sense of well-being is thereby improved, which strongly enhances the effect of contemporaneous counseling to achieve greater and more lasting behavior change. The model postulates that intervening directly on clients' perceived well-being (and improving it) is associated with an indirect reduction in addiction severity, frequency of drug use, and other AIDS behaviors.[28,29]

Using the LIGHT Model intervention, nurses: bond with clients, assist them to overcome perceived barriers to their well-being given their personal circumstances, educate them about AIDS, and assist them to use their full energy to develop their talents in the pursuit of self-improvement. Extensive nursing assessments, talent assessments, studies of "a typical day," and teaching/counseling sessions are used. The intervention is

rigorous in its: 1) non-judgmental deference to client-perceived definitions of barriers to their maximum well-being, 2) demand that nurses learn from the client (a key to achieving strong bonding in the relatively short teaching/counseling sessions), 3) methodology for the nurse to communicate effectively to the client that the nurse values the client, and 4) facilitation of clients' use of talents. For the hard-to-reach populations of long-term IVDUs, their families, and their social network members living in the harshest urban environments with histories of non-responsiveness to multiple drug treatment programs and incarcerations, behavior change must start with a sincere, effectively-communicated unconditional valuing of the clients.

The Personalized Nursing LIGHT Model posits that reduction of high-risk behaviors among hard-to-reach populations of IVDUs having histories of non-responsiveness to more traditional drug treatment methodologies may be achieved indirectly, through a direct intervention on the IVDUs' perceived well-being. Well-being of clients is enhanced when clients themselves take action to remedy their focal concerns and build upon their talents in the pursuit of excellence. The most efficient mechanism for improvement of a client's sense of well-being is for the individual to take action on his/her own behalf to improve well-being. The LIGHTHOUSE Lodge Program is designed to assist them to do just that.

One track of the Personalized Nursing LIGHT Model is called Personalized Care. All actions are taken by the nurse on behalf of the client with the intent of improving client's sense of well-being. The other track of the Personalized Nursing LIGHT Model is called Personalized Action. All actions are taken by the client. Both tracks are described with the acronym LIGHT, a symbol based on Florence Nightingale's nursing lantern:

Personalized Care	Personalized Action
L ove the client	L ove yourself
I ntend to help	I dentify a focal concern
G ive care gently	G ive yourself a goal
H elp the client improve well-being	H ave confidence
T each the process to the client	T ake action

Bonding with Clients. Bonding with the client is a unique concept that must take place simultaneously with client assessment, teaching, and planning. Bonding means a state of mutual respect, admiration, and caring between the nurse and the client. This is accomplished by using a process called TAP (Touch, Assess, and Plan). The first step of bonding is to Touch the client's soul. This is done by sincerely valuing something about the client and learning from him/her. Next, nurses Assess the barriers to the client's well-being. Well-being is a variable that includes health, but is not limited to physical health. When well-being is high, it is assumed a person is "on track for his/her destiny,"[30] using talents and moving forward toward self actualization. One of the main goals of the intervention is to assist persons to Plan their first step toward improving their well-being within their maximum potential.[2,30,29] In this project, the work in the LIGHTHOUSE Lodge group living and group working projects clients select will facilitate use of their talents.

Behavior Change. The LIGHT Model and the Lodge Society Model are both structured to involve clients in their own recovery process. They are based on the philosophy that solving one's problems and using one's talents can be a reinforcing process. It is felt that the clients must learn to love themselves and to have confidence to take positive action on their own behalf in order to increase their sense of well-being. One of the treatment goals is to eliminate negative emotional states that serve as motivations for drug use and identify alternative reinforcers for positive actions such as group ownership of a business. Clients are helped to plan for anticipated and unanticipated changes rather than react when changes occur. The theory underlying this project is that as the clients see gains being made in controlling the environment and in developing personal strengths, his/her sense of well-being and ability to take control of life will increase.

PRELIMINARY STUDIES

In early work, Andersen[31,32] documented the high number of medical problems and emergency room visits of IVDUs. In fact, it was learned that the emergency room is the primary source of medical care for most inner-city drug addicts. A program of research began to utilize a nursing care intervention model, the Personalized Nursing LIGHT Model, to effect behavior change in IVDUs reached during their stay in a hospital emergency room. The applicant has had extensive and successful experience in providing a wide variety of care and support services to IVDUs and in reducing their addiction severity and high-risk behaviors related to AIDS. Use of the Personalized LIGHT Model has been shown to be associated with a decrease in drug abuse and stress in a treatment-resistant group of IVDU women in an emergency room,[33,28] a decrease in addiction severity in chemically-dependent women prisoners,[34] and a decrease in high-risk behaviors related to AIDS transmission.[35,28] The following are brief summaries of each of the applicant's prior projects using the LIGHT Model.

Detroit Receiving Hospital (1980-1984) Nursing Outreach Care and Counseling to IVDUs (Study I)

Drug-dependent women (N = 55) and members of their social network (N = 54) were treated in a hospital ER (Detroit Receiving Hospital, one of the proposed host hospitals for this project) in a randomized clinical trial. Following the initial interview, experimental subjects were counseled in their homes by a project nurse toward a goal of decreasing their daily drug cost and perceived stress. Many were counseled in the presence of their social network members in the program's experimental home-based outreach drug treatment program based on the Personalized Nursing treatment model.

The experimental group reported a lower daily drug cost ($F(1,95) = 2.90$; $p = 0.09$), a lower daily heroin cost ($U = 165$; $p = .01$), less perceived stress ($F(1,84) = 3.00$; $p = .09$) and emotional distress ($F(1,83) = 3.70$; $p = .06$) than control subjects at the eight-week post-test. The experimental subjects also reported less perceived stress ($t(65) = -2.35$; $p = .02$) at six-month follow-up than control subjects. It was found that

results could be improved if members of the experimental clients' social networks were treated simultaneously and if project nurses weree correctly utilizing the model.

State of Michigan, Michigan Department of Corrections (1986-1987); Nursing Outreach Care and Counseling to IVDUs in Michigan Women's Prisons (Study 2)

Personalized Nursing Corporation, P.C. conducted a successful nursing outreach and counseling project for IVDUs, under contract with State of Michigan Department of Corrections, with chemically-dependent female felons in three Michigan prisons. Women (N = 112) participated in an initial pre-test and in-prison counselling session. Seventeen were released from prison during the project and participated in four home nursing visits. Project nurses met the subjects in their homes in the presence of their social networks. The 17 released women received 20 group treatment sessions in prison followed by four home nursing visits in their homes for follow-up treatment after community placement. Their addiction severity (measured by the Addiction Severity Index),[36] was compared to a group of 19 untreated, chemically-dependent female offenders recently released in the community. Treatment consisted of counseling by nurses using the Personalized Nursing LIGHT Model.

Ninety-five percent (95%) of the women who completed the treatment program completed the post-test 22 weeks after pre-test, while 83% of the comparison women completed the post-test eight weeks after the pre-test. When the treatment group was compared to the comparison group with respect to the number of improved categories related to addiction severity, the treated group showed a statistically significantly higher number of improved categories (x = 5.46, p<.05) than the comparison group. Results further showed that overall the women in the experimental treatment group improved in five out of seven of the Addiction Severity Index (ASI) categories related to addiction severity (medical, family/social, alcohol use, drug use, legal, psychiatric, and employment), while comparison women improved in only two categories. The treated women improved significantly in areas of drug use (t = 5.01, p>.01) and family/social status (t = 4.45, p>.01). They also showed some improvement in the areas of medical status, legal status, and psychiatric status.

NIDA Contract (1987-1990): AIDS Outreach to Emergency Rooms & Detoxification Units (Study 3)

The applicant is presently completing an exploratory/demonstration research project which provides nursing outreach in three geographical sites, Detroit, New York, and Baltimore. The project is designed to reach and serve a hard-to-reach population of 2,000 IVDUs, at high-risk for AIDS acquisition and transmission. This NIDA-funded AIDS demonstration project has given the applicant invaluable experience in providing care, counseling, coordinated service delivery, and conducting follow-up with IVDUs in three geographic locations. It has been found that 38% of the emergency unit clients are subsequently hospitalized often using the hospitalization to withdraw themselves from drugs. The current demonstration project has demonstrated a capacity to reach large numbers of IVDUs who are not in a treatment program and who are

at high-risk for HIV/AIDS. In addition, the Personalized Nursing LIGHT Model staff has provided a wide variety of services to these individuals.

To date, approximately 1,933 IVDUs have been served in this project. Preliminary analysis on early follow-up data from 348 clients shows statistically significant reductions ($p<.01$) were achieved in the frequency of IV use of heroin, cocaine, and speedballs. Of those reporting heroin use at pre-test, their pre-test mean frequency of use was 4.9 on the following scale: 4 = once/week and 5 = 2-3 times/week. These same individuals reported a post-test mean of 3 (3 = 2-3 times/month), showing a 39% decrease in frequency of use. Similarly, for those reporting cocaine use at pre-test, their pre-test mean frequency of use was 4. They reported a post-test mean of 2.6 (2 = once/month), showing a 35% decrease in frequency of use. Improvement was also achieved for those reporting speedball use. At pre-test, their mean frequency of use was 3.2, and their post-test mean frequency of use was 2.2. They showed a 31% decrease in frequency of speedball use. Additionally, the mean number of people with whom participants shared works during the prior month decreased by 90%, from a pre-test mean frequency of 2 to a post-test mean of 0.2., which was statistically significant at the .01 level. Moreover, the mean frequencies of key high-risk behaviors (sharing of works and cookers) were significantly ($p<.01$) decreased.

Summary of Preliminary Accomplishments

The applicant has succeeded in networking with a host of health-care-providing elements: three very different hospital administrations, hospital emergency room staff, various community-based detoxification programs, social support service agencies, and the home/family/social-network members of these IVDUs. Thus, the applicant already has a substantial body of experience in reaching and serving the hard-to-reach in hospitals in three sites, providing LIGHT Model care, and referring them for additional services as needed.

It has been demonstrated: 1) large numbers of hard-to-reach clients can be reached in hospitals and detoxification programs (Studies 1 & 3); 2) promising intervention strategies have been established (Studies 1, 2, & 3); 3) addiction severity can be measured (Study 2); 4) AIDS high-risk behaviors can be measured (Study 3); 5) studies in hospital ERs in three states have been conducted (Study 3); and 6) randomized clinical trials in a hospital ER setting with adequate follow-up can be conducted (Study 1). Approximately 40% of the drug users in hospital ERs are hospitalized and most are detoxified during their hospitalization due to inaccessibility of street drugs (Study 3).

REFERENCES

1 Moore, J. (1987, February 14). State plans to warn drug users about AIDS. Detroit Free Press, pp. 1a, 11a.

2 National Institute On Drug Abuse (1988). Data from the Drug Abuse Warning Network, 1987. (DHHS Publication No. ADM 88-1584). Rockville, MD.

3 Michigan Department of Public Health (1989, September). Michigan's Continuation Application for AIDS Prevention and Surveillance Project January 1 - December 31, 1990, Center for Health Promotion.

4 Temko, A. (1989, December 28). Italian look for Delancy Street complex: Masterpiece of social design. The San Francisco Chronicle.

5 Fairweather, G.W., Sanders, D.H., Maynard, H., Cressler, D.L., & Bleck, D.S. (1969). Community life for the mentally ill: An alternative to institutional care. Chicago: Aldine.

6 Brown, B.S. & Beschner, G.M. (1989). AIDS & HIV infection--implications for drug abuse treatment. The Journal of Drug Issues, 19 (1), 141-162.

7 Brown, B.S. & Ashery, R.S. (1979). Aftercare in drug abuse programing. In R.I. DuPont, A. Goldstein, J. O'Donnell, & B. Brown (Eds.) Handbook On Drug Abuse, Washington, D.C.: National Institute on Drug Abuse (pp. 165-173).

8 De Leon, G. (1981). The Role of Rehabilitation. In G.G. Nahas and H.C. Frick (Eds.), Drug Abuse in the Modern World, New York: Pergamon Press (pp. 303).

9 Hawkins, J.D. & Catalano, R.F. (1985). Aftercare in drug abuse treatment. The International Journal of the Addictions, 20 (6 & 7), 917-945.

10 Dell Orto, A.E. (1974). The role & resources of the family during the drug rehabilitation process. Journal Psychodelic Drugs, 6, 435-445.

11 Levy, B. (1972). Five years after: A follow-up of 50 narcotic addicts. American Journal of Psychiatry, 7, 102-106.

12 Moberg, D.P., Krause, W.K., & Klein, P.E. (1982). Post-treatment drinking behavior among inpatients from an industrial alcoholism program. International Journal of Addictions, 17, 549-567.

13 Krohn, M.D., Lance-Kaduce, L., Radosevich, M. & Akers, R.L. (1980). Cessation of alcohol and drug use among adolescents: A social learning model. Paper presented at Society of Social Problems, Annual Meeting, New York.

14 Stead, P. & Viders, J. (1979). A "sharp" approach to treating alcoholism. Social Work, 144-149.

15 Savage, L.J. & Simpson, D.D. (1979). Criminal behaviors of opoid addicts during a four-year follow-up after drug abuse treatment. (IBR Report 79-12) Fort Worth, TX: Institute of Behavioral Research.

16 Simpson, D.D. (1981). Employment among opoid addicts during a four-year follow-up after drug abuse treatment. Journal of Drug Issues, 11, 435-449.

17 Waldorf, D. & Biernacki, P. (1981). The natural recovery from opiate addiction: Some preliminary findings. Journal of Drug Issues, 2, 61-74.

18 Fairweather, G.W. (Ed.) (1980). The Fairweather lodge: a twenty-five year retrospect. New Directions for Mental Health Services, 7.

19 Fairweather, G.W. (Ed.) (1964). Social Psychology in Treating Mental Illness: An Experimental Approach. New York: Wiley.

20 Fairweather, G.W. & Tornatzyk, L.G. (1977). Experimental methods for social policy research. Elmsford, New York: Pergamon Press.

21 Aristotle (1984). Nicomachean ethics; Physics; Eudemian ethics. In J. Barnes (Ed.). The Complete Works of Aristotle, Princeton University Press.

22 Rogers, M.E. (1970). An Introduction to the Theoretical Basis of Nursing. Philadelphia: F.A. Davis Co.

23 Rogers, M.E. (1981). Science of unitary man. A paradigm for nursing. In Applied Systems and Cybernetics. G. Lasker: (Ed.) (pp. 1719-1277), New York: Pergamon Press.

24 Rogers, M.E. (1983). Charting the future. Paper presented at the First National Rogerian Conference, New York University, New York.

25 Rogers, M.E. (1988). Nursing science and art: a perspective. Nursing Science Quarterly, 1(3), pp. 99-102.

26 Rogers, M.E. (1988). Personal letter to authors critiquing this paper, November 8, 1988.

27 Rogers, M.E. (1989). Personal communication, Washington, DC, February 16, 1989.

28 Andersen, M.D. (1986). Personalized Nursing: A brief effective treatment model for drug-dependent women. International Journal of Addictions, 21(1), 105-122.

29 Andersen, M.D., Smereck, G.A.D., & Braunstein, M.S. (1990). LIGHT Model: A model for reducing high-risk AIDS behaviors in IV drug users. Manuscript submitted for publication.

30 Andersen, M.D. and Smereck, G.A.D. (1989). Personalized Nursing LIGHT Model. Nursing Science Quarterly, Fall, 2(3), pp. 120-130.

31 Andersen, M.D. (1980). Health needs of drug-dependent clients: focus on women. Women and Health, 5(1), 23-33.

32 Andersen, M.D. (1979). Life change & illness in two drug treatment modalities. Issues in Mental Health Nursing, 2 (2), 39-52.

33 Andersen, M.D. (1982). Personalized Nursing: A unique approach to drug-dependent women. Journal of Emergency Nursing, 8(5), 225-231.

34 Andersen, M.D. & Braunstein, M.S. (in press). Conceptions of therapy: Personalized Nursing LIGHT Model with chemically-dependent female offenders. Int. Mieczkowski (Ed.). Drugs & Crime Reader. Needham Heights, MA: Allyn & Bacon.

35 Andersen, M.D., Smereck, G.A.D., & Braunstein, M.S. (1989). Intravenous drug users who are high-risk for AIDS acquisition and transmission in hospital emergency rooms. Presented at the 17th International Institute on Prevention and Treatment of Drug Dependence, Pontault-Combault, France, June.

36 McLellan, A.T., Luborsky, L., Cacciola, T., Griffith, J., McGahen, P. & O'Brien, C.P. (1985). Guide to the Addiction Severity Index: Background, Administration, and Field Testing Results. (DHHS Publication No. ADM 85-1419), Rockville, MD: National Institute On Drug Abuse.

[Profiles of Rev. Lee Earl, provided by Charlene Johnson are retained in committee files.]

Burke, Justin (AP), "Crack house cleanup by church sends dealers packing: In restoring neighborhood, REACH solves 2 problems; Program renovates pride in neighborhood." The Flint Journal, August 18, 1988.

Chandler, Michele, "Investor in Faith: REACH chief banks on neighborhood's sharing and caring." Detroit Free Press, April 23, 1990.

"Community Access News Salutes Pastor of the Month." Community Access News, January, 1989.

Wilkerson, Isabel, "Detroit citizens join with church to rid community of drugs." The New York Times, June 29, 1988.

Ball, Zachare, "Minister's plan to renovate homes gets support it needs." Detroit Free Press, August 25, 1988.

Ball, Zachare, "Dreamer and Doer: Tenacious Pastor sees problems as opportunities." Detroit Free Press, December 7, 1988.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515

June 4, 1990

Marilyn L. Poland, Ph.D., R.N.
Dept. of Obstetrics/Gynecology
Wayne State University Medical School
275 East Hancock
Detroit, MI 48201

Dear Dr. Poland:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Getting Straight: Overcoming Treatment Barriers for Addicted Mothers and Their Children," in Detroit on April 23, 1990. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by June 13 with any necessary corrections.

In addition, I am requesting a response in writing to the following questions for inclusion in the hearing record.

1. You mentioned a dearth of expertise about among professionals who work in emergency rooms and walk-in clinics regarding drug abuse and pregnancy. Are you aware of any local, state or national efforts to train staff in these settings so that they can respond and refer appropriately?

2. What could the government do to encourage such training efforts? Are there incentives or specific forms of technical assistance that we could offer? Would training grants to institutions be appropriate? What kinds of institutions?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families
Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

Wayne State University
School of Medicine

HUTZEL HOSPITAL
THE DETROIT MEDICAL CENTER

Department of
Obstetrics-Gynecology

275 East Hancock Avenue
Detroit, Michigan 48201
(313) 577-1485

Robert J. Sokol, M.D.
Professor, Chairman and Chief

C.S. Mott Center for Human
Growth and Development
Robert J. Sokol, M.D., Director
Kamran S. Moghissi, M.D., Co-Director
Ernest L. Abel, Ph.D., Director of Operations

June 13, 1990

George Miller, Chairman
Select Committee on Children,
Youth, and Families
U.S. House of Representatives
385 House Office Building
Annex 2
Washington, DC 20515

Dear Mr. Miller:

Thank you again for inviting me to testify on April 23, 1990 for the hearing, "Getting Straight: Overcoming Treatment Barriers for Addicted Mothers and Their Children." I am enclosing a corrected copy of my testimony.

The questions you posed, while straight forward and focused on a particular aspect of prenatal care, are really very complex and touch the central core of our prenatal access problem. I will address each one in turn.

1. Are you aware of any local, state or national efforts to train staff in emergency rooms and walk-in clinics so that they can respond and refer appropriately?

   I am not aware of any programs that specifically train emergency room and walk-in staff to refer pregnant women to prenatal care or drug abuse programs. According to the women we interviewed, many staff in these centers do refer them for appropriate care; it is the women who choose to remain in these centers. There were some physicians in walk-in clinics who wanted to continue to see pregnant women as long as they had no complications. Most women understood they would be delivered at Hutzel Hospital by an obstetrician there and be classified as "walk-ins." The problem with these few physicians is that they offered substandard medical care and did not assess substance use, much less refer the women for treatment. The incentives for the women to use walk-in clinics include convenience, they are checked by a doctor, and they do not have to disclose drug or alcohol use. The incentive for the physicians to see the women is an economic one. Thus there is a economic, social, and attitudinal niche for walk-in clinics and emergency rooms.

2. What could the government do to encourage such training efforts? Are there incentives or specific forms of technical assistance that we could offer? Would training grants to institutions be appropriate? What kinds of institutions?

There are several things the government can do to address this problem. First, it would be important to know how widespread the use of emergency rooms and walk-in clinics is by pregnant women - especially those who abuse substances. At present, our Detroit study is the only one I know of that asked the question. Second, the idea of training programs for health professionals (doctors, nurses, and social workers), in private and public prenatal clinics is an excellent way to improve communication and assessment skills. I would not offer training programs for personnel in emergency rooms and walk-in centers. There are economic incentives for some to continue to see pregnant women and training programs would not alter that.

If pregnant women abusing drugs felt more comfortable at prenatal clinics, they would be less likely to choose walk-in clinics and emergency rooms. Training programs for professionals in prenatal settings would be best coordinated centrally by an agency with an interdisciplinary team of experts in maternal and child health who are sensitive to the values and lifestyles of the women we want to reach. In my experience, the best place for such an effort is the Maternal-Child Health Bureau of the Office of Maternal and Child Health, through it well-established networks of regional offices. If health professionals could be taught assessment and counseling skills, they could not only identify women in need of substance abuse service, but provide some treatment on site in the clinics. This has been shown to be effective in some women addicted to cigarettes and alcohol and promotes the one stop shopping approach. One clear incentive for physicians and clinics to participate in such an effort would be a graduated medicaid reimbursement rate tied to the identification of need and documented counseling services. Thus the health professionals in the standard prenatal settings would be reimbursed for extra time spent with their patients. It would also be important to tie the prenatal services with accessible substance abuse programs and residential halfway houses in the area.

Four points characterize the kind of training program I think would be most effective.

1) Prenatal clinics must be made more "user friendly" than the emergency rooms and the walk-in centers. Working with health professionals would do much to improve the social atmosphere.

2) Train health professionals to screen, counsel, and refer for substance abuse, physical abuse, and other prenatal "risk" indicators.

3) Use former drug abusing women to assist in the development of sensitive screening, counseling, and referral formats and methods of serving women who are not yet willing to seek substance abuse treatment.

4) Provide a system of incentives to clinics, hospitals, and private physicians to perform the necessary counseling and referral.

These are important questions and I believe they address a wide gap in our current system of provision of prenatal care and substance abuse services to pregnant women. I hope this information is helpful to you. If I can be of further assistance, please let me know.

Sincerely yours,

Marilyn L. Poland, Ph.D., R.N.
Associate Professor
Dept. of Obstetric and Gynecology

MLP:pj

Enclosure

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515

June 4, 1990

Joan Walker, M.S.W., Administrator
Michigan Office of Substance Abuse Services
P.O. Box 30206
Lansing, MI 48909

Dear Ms. Walker:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Getting Straight: Overcoming Treatment Barriers for Addicted Mothers and Their Children," in Detroit on April 23, 1990. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by June 13 with any necessary corrections.

In addition, I am requesting a response in writing to the following questions for inclusion in the hearing record.

1. What are the state's plans for spending the monies earmarked for women's treatment in the Alcohol, Drug Abuse and Mental Health Block Grant?

2. Are you going to spend the $1 million dollars from the women's treatment set-aside for "women only" treatment programs? And if not, why not?

3. When you give funds first to the 18 coordinating agencies, and they, in turn, allocate dollars to specific programs, are you still able to specify the criteria they must employ in selecting individual program recipients? In other words, if you decide what an effective women's treatment program should look like, are you in a position, using this financial distribution system, to fund only that type of program?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
OFFICE OF SUBSTANCE ABUSE SERVICES
2150 Apollo Drive • P.O. Box 30206
LANSING, MICHIGAN 48909
JOAN WALKER, Administrator

June 8, 1990

The Honorable George Miller
Chairman
Select Committee on Children, Youth,
and Families
U.S. House of Representatives
385 House Office Building Annex 2
Washington, DC 20515

Dear Congressman Miller:

It was a pleasure to testify before the Select Committee on Children, Youth, and Families. Prior to being appointed as Administrator of the Office of Substance Abuse Services, I was very active in the child welfare system, and an active supporter to the creation of the Select Committee.

The transcript of my comments before the committee are accurate. In response to your additional questions.

Michigan will be spending considerably more of the ADAMHA Block Grant dollars on women than the 10% which is earmarked. We have identified this as one of our top two priority populations on which to focus our resources.

As stated in my testimony, Michigan has only 16 licensed substance abuse prevention and treatment programs. This is out of over 700 licensed programs. We recognize that these programs will require additional supportive services in order to be effective. As we build this treatment capacity, we will definitely be targeting our dollars specifically on "women only" treatment programs. We have a lot to learn about how to successfully treat this population. As our treatment capacity increases, and as we learn more, we might change this policy.

MICHIGAN

In response to your last question, regarding the state's ability to direct our local coordinating agencies to fund one type of program which we deem successful, we have that ability, but would probably not exercise it in the manner stated. We would offer strong policy statements which would recognize and allow for the divergent populations of women, and the geographic areas in which they reside.

Please feel free to contact me if you have any additional questions.

Sincerely,

Joan Walker
Administrator

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515

June 4, 1990

Charlene Johnson
President and Chief Operating Officer
REACH
1840 Midland
Detroit, MI 48238

Dear Mrs. Johnson:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Getting Straight: Overcoming Treatment Barriers for Addicted Mothers and Their Children," in Detroit on April 23, 1990. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by June 13 with any necessary corrections.

In addition, I am requesting a response in writing to the following questions for inclusion in the hearing record.

1. The Extended Family Home that REACH has proposed seems to have numerous requirements and substantial supervision of the young women it plans to serve. Have any young women expressed an interest in entering the program when it opens?

2. What will the admission criteria for selecting the Home residents be? Who will select them? Am I right in assuming that a woman would be ineligible if she had a history of drug use?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

LEE A. EARL
Chairman Of The Board

CHARLENE JOHNSON
President & Chief Operating Officer

JUN 25 RECD

June 20, 1990

Mr. George Miller, Chairman
U. S. House of Representatives
Select Committee on Children, Youth, and Families
385 House Office Building Annex 2
Washington, D. C. 20515

Dear Mr. Miller:

Enclosed please find my response to the questions posed in your letter of June 4, 1990. I'm sorry that you did not receive them prior to June 13, but perhaps the information can still be helpful.

We have begun recruiting women for the Extended Family Home. We have contacted homes for unwed girls, as well as homeless shelters and group homes for abused women and recovering substance abusers. To date we have received five (5) referrals and have had two interviews with potential residents.

Please see the enclosed information sheet regarding admission criteria for the Home. The Housemother along with the Program Director and Social Worker will make the final selection for admission. A woman who has a history of drug use would not be ineligible. Such women would be screened according to the criteria set for any other women. However, it is important to remember that our primary focus is on prevention. Therefore, our major efforts are directed at women who have not used drugs but who are at risk because of the volatile social/economic factors they face, particularly the lack of family support to assist them in becoming productive members of society.

I want to thank you for your interest and concern regarding women and substance abuse, prevention, and treatment. It takes all of us working at various tasks to solve the tremendous problems we are facing.

Yours in Community Service,

Charlene Johnson/rsm

Charlene Johnson
President and CEO

CJ/rsm
Enclosures

EXTENDED FAMILY HOME

Objectives

(1) To provide an "extended family" home for up to five AFDC recipients who meet the following requirements:

a. Willingness to continue education or participate in job training;
b. No more than one pre-school age child;
c. Willingness to pay room and board; and,
d. Willingness to sign a one-year, renewable lease and Program-Participant Agreement.

(2) To provide quality, on-site day care services for the children of these mothers.

(3) To assist these mothers with household management and parenting skills.

(4) To provide other support services such as counseling, transportation, etc., as may be needed to assist these women in completing their education and gain meaningful employment.

Target Population

The target population, age 18 to 22, is an extremely vulnerable and often struggling head of household who is attempting to better her condition in life by completing her education and obtaining employment. This endeavor will enable her to come off the Department of Social Service's client list and maintain a productive life.

Facility

The "Extended Family Home" is a single family house located at 94 Moss (corner of Second) in Highland Park, Michigan 48203.

The house contains an area of 2,322 total square feet, 6 bedrooms, 2 1/2 baths, finished recreation room, patio-fenced backyard, side drive garage, and exterior of stucco over brick.

Staff

Required staff will be one house mother who would be responsible for managing the home, to include cooperative services provided by residents who will assist with the day-to-day operation of the home. The house mother will report to the Director of Programs for REACH, Inc., who is responsible for the overall program, its staffing, administration, resident recruitment, funding, and other such related responsibilities. Other necessary support services will be coordinated on a contractual basis.

Precis

Organization

REACH, Inc. (Reach Everyone, Administer Care & Help)
1840 Midland
Detroit, MI 48238
(313) 868-2659
Key Staff Contact: RANTINE S. McKESSON

History

REACH, Inc. is a non-profit community development and community service organization which was organized out of the "Weekday Ministry" of the Twelfth Street Missionary Baptist Church, which began in 1982.

Established in 1986 to meet the socio-economic needs of the Pilgrim Village community (bound by John C. Lodge Freeway, McNichols, Livernois and Woodrow Wilson Streets), REACH endeavors to become a model of urban redevelopment that can be exported to any city in America.

Organizational Goals

- To provide services to meet the needs of low- to moderate-income residents of metropolitan Detroit.
- To promote economic stability by providing an environment whereby skills and information can be acquired to achieve economic self-sufficiency.
- To share with other people and groups throughout this state the ideas and concepts on community and economic development efforts.
- To contribute to the physical revitalization of the residential and commercial areas of Pilgrim Village.
- To strive for the strengthening of the family and church, and neighborhoods institutions.

Scope of Services

REACH offers a comprehensive approach to urban redevelopment.

- *Abandoned Housing/Acquisition/Rehabilitation and Resale Program*
- *Child Development Center*
- *Weekly Food Distribution Program*
- *Summer Youth Program*
- *Senior Citizen Outreach Program*
- *Computer Awareness Program*
- *Small Business Development Center*
- *Substance Abuse Prevention*
- *Crime Prevention Program*

Major Accomplishments

(1) Our weekly food distribution program has distributed groceries worth over **$500,000** to the poor.

(2) Our senior citizen's program has provided attention and care to over **500** senior citizens.

(3) Our child development center provided child-care services to over **200** parents.

(4) Rehabilitated 3 commercial buildings for use as a community service center.

and restaurant.

(5) Our summer youth program has benefitted over 200 children.

(6) Our abandoned housing acquisition/resale program has rehabilitated 15 dilapidated houses to provide decent, affordable homes for families and job training to unemployed men and women.

Awards and Recognitions

Detroit City Council SNAP Award for Food Distribution Program in 1989.

S.E.M.C.O.E.H. Outstanding Project Award for innovative housing programs that "can serve as a model for others."

Nominated for the National Community Development Association's Audrey Nelson Community Development Achievement Award for Exemplary uses of CDBG funds in 1989.

Mentioned by: New York Times, CNN, ABC-TV, USA Today, Detroit News, Detroit Free Press, all Detroit TV Stations, and various other media outlets.

Board Officers

Rev. Lee A. Earl, Chairman

Pastor, Twelfth Street Missionary Baptist Church.
Founder, REACH, Inc.
Former executive, Consumer's Power Corp.
Master of Theology, Ashland Theological Seminary, Wayne State University.

Licensed real estate agent.
Member, National Bank of Detroit CDC Community Advisory Board.

Rev. Cullen Hill, Vice Chairman

Pastor, Greater Concord Baptist Church of Detroit.
Board Chairman, Todd Phillips Boys Home.

Mr. Billy Rodgers, Sec./Treasurer

Retired corrections Dept. Supervison.
Treasurer, Twelfth Street Missionary Baptist Church.

Corporate Officer

Mrs. Charlene Johnson, President

Co-founder, REACH, Inc.
M. Ed., Wayne State University.
Director of Weekday Ministries, Twelfth Street Missionary Baptist Church.
Member, Manufacturers Bank Community Advisory Board.
Member, First of America Community Advisory Board.
Member, Detroit Neighborhood Alliance.
Detroit Chairperson, Michigan Housing Coalition Board of Directors.
Chairperson, Detroit Area Reinvestment Alliance.
1989 National Winner Salute to Black Women who Make Things Happen, NCNW.
Family Life Educator, Detroit Public Schools.

Annual Budget

Total Operating Budget $800,000

Documents Available Upon Request

501 (c)(3) Tax Exempt Status
Articles of Incorporation
Financial Statement